January 2004

STATE OF THE STATES

Cultivating Hope in Rough Terrain

STATE COVERAGE INITIATIVES

AcademyHealth

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AcademyHealth is the national program office for SCI, an initiative of The Robert Wood Johnson Foundation.

FOREWORD

In 2003, states struggled for the third consecutive year to remain solvent in the face of falling revenues and budget-breaking expenditures. Although the past year has pushed states to their limits, it is worth remembering that even the most difficult experiences have much to teach us.

What the states have demonstrated during this time is their unfailing commitment to addressing the health care needs of their most vulnerable citizens. It is one thing to make coverage a priority when the economy is stable and national interest is focused on domestic issues. But to keep health insurance on the agenda in a period of fiscal crisis and competing federal concerns about defense and homeland security—as the states have done in 2003—is quite another.

State of the States: Cultivating Hope in Rough Terrain tells the story of the states' challenges and achievements in 2003 as they strove to maintain health care coverage through their public programs, and to balance competition and regulation in their insurance markets. Some states even managed to expand coverage to new populations in this trying period.

The report also describes the reemergence of health care on the national agenda in 2003, with the historic passage of legislation to reform Medicare in November, and discussions about universal health care coverage—as put forth by the Democratic presidential candidates—circulating at the federal level with a prominence not seen since the Clinton era.

As always, the State Coverage Initiatives (SCI) team tried to assist states through this turbulent period. The past year was a time of transitions for SCI. In August, we said goodbye to Vickie Gates, SCI's talented and dedicated program director since 2000, and I assumed the role of interim director for the team. As the former national program director for The Robert Wood Johnson Foundation's Health Care for the Uninsured program, State Initiatives in Health Reform program, and the SCI program prior to Vickie's tenure, this was familiar terrain for me.

While I would have hoped this country would have made more progress in addressing the perennial problems associated with the large number of uninsured, it has been a pleasure to step back into the role of collaborating with states and the Foundation to improve health coverage.

In January 2004, we will welcome Alice Burton as SCI's new program director. Alice will also be the leader of AcademyHealth's State Health Policy Group, which carries out our important work for the Health Resources and Services Administration (HRSA) to provide technical assistance to states and U.S. territories that have received state health planning grants. Alice comes to us from the Maryland Department of Health and Mental Hygiene, where she served most recently as director of planning and development.

SCI remains dedicated to helping states to help their uninsured through all the ups and downs of state economies and politics. As always, please contact the team at sci@academyhealth.org at any time with questions or suggestions. We look forward to working with you to continue cultivating hope in the states for years to come.

W. David Helms
AcademyHealth President and CEO

EXECUTIVE SUMMARY

For the third straight year, the states have struggled to endure in a desert-like economic environment. Across the country, state decision makers have learned to focus on maintaining rather than expanding health coverage, and to make the difficult decision of whether to reduce benefits, eligibility, or outreach for public programs in order to balance their budgets. States have shown that, in policy and politics, as in nature, those who want to survive must adapt to their surroundings.

At year's end, the national economy showed the first signs of real growth since the country slipped into a recession in 2001. However, experts agree that the situation in states is far worse than the general economic climate would suggest. Unfortunately, state governments will remain trapped by their poor fiscal conditions for the foreseeable future.

In 2003, they faced a combined financial shortfall of more than $70 billion, as well as a greater demand for coverage and continued increases in health care costs. The average Medicaid growth rate in fiscal year 2003 was 8 percent, while the Gross Domestic Product grew just 2 percent over a similar time period.

States adjusted to these realities by tapping whatever resources they could, including rainy-day funds, tobacco settlement monies, and increased sin taxes. But after weathering two previous years of economic turmoil, many had already exhausted these reserves by the time 2003 rolled around. They turned instead to minimizing their outlays, reducing Medicaid eligibility and benefits, and adopting pharmaceutical cost-containment mechanisms.

Meanwhile, at the national level, the federal government engaged in serious discussions about restructuring public health care programs for the first time in years. Indeed, in November, the landmark passage of legislation to reform Medicare modernized the program and established at last a federal program that provides prescription drug coverage to our nation's seniors. For better or for worse, the Bush administration's plan to reform Medicaid through a block-grant program met a different fate: It collapsed after months of negotiations and partisan debates over ideological differences about how Medicaid should be organized and financed.

At the same time, the 2004 Democratic presidential candidates clamored for the attention of voters across the country. In an effort to address the concerns of an aging U.S. population, their approaches are geared toward achieving universal coverage—a marked contrast to the incremental approaches that have been favored over the past decade.

In addition to significant fiscal and programmatic difficulties, states also faced sizable challenges in stabilizing their private health insurance markets in 2003. Insurance premiums continued to climb rapidly. Premiums for job-based health benefits rose by double-digits for the third consecutive year—by 13.9 percent in the U.S. in 2003.

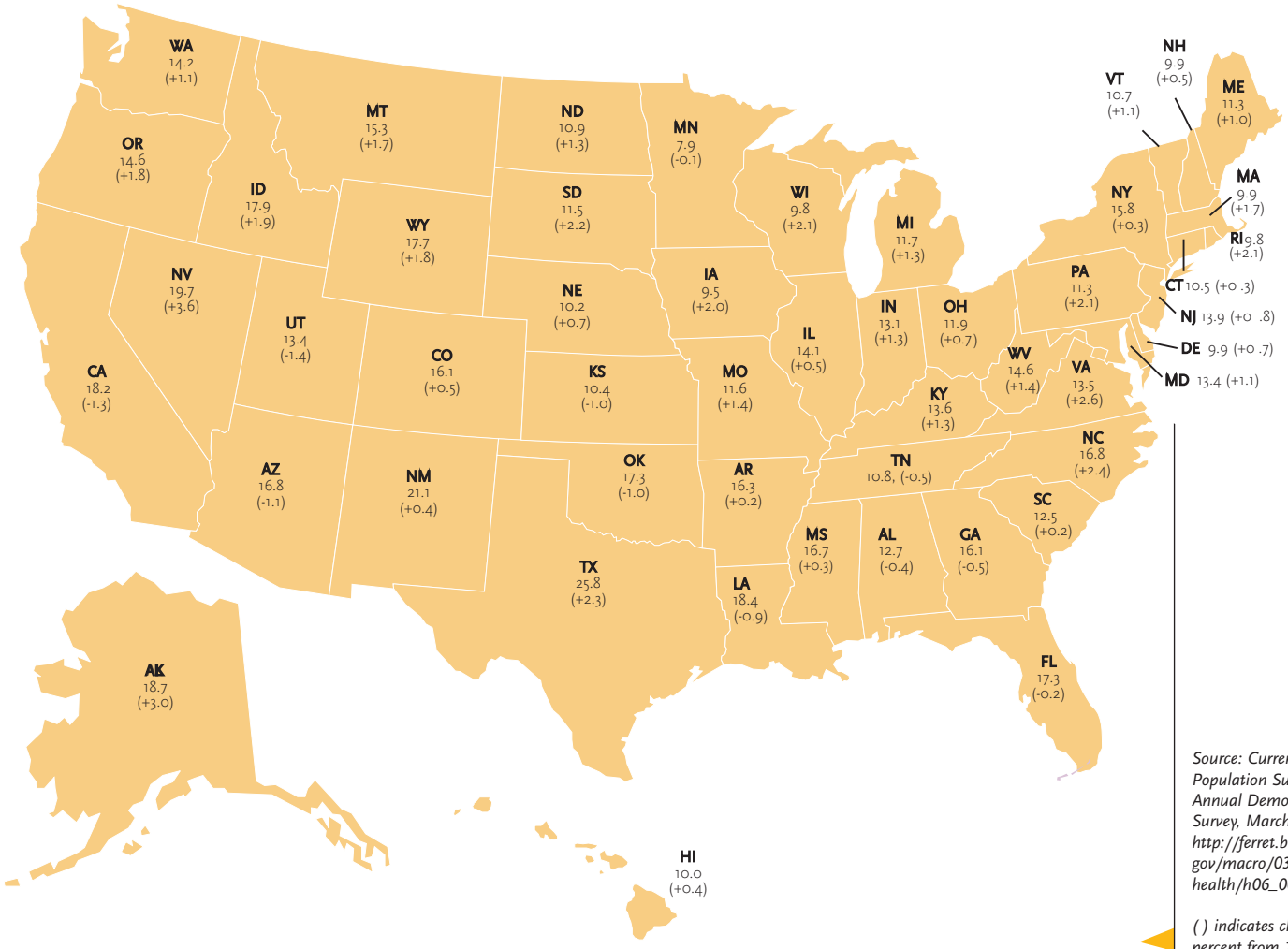
Consequently, many employers were forced to reduce their benefits packages or eliminate health insurance altogether. With an increasing share of the workforce lacking employer-sponsored coverage, states had to cope with an influx of working uninsured.

Despite myriad challenges, 2003 was not totally devoid of sunshine for states. In June, the federal government enacted the federal Jobs and Growth Relief Reconciliation Act of 2003, which provided states with up to $20 billion in fiscal relief for Medicaid and other state programs.

Moreover, many states were able to continue to address their uninsured with the help of grants provided through The Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program and the Health Resources and Services Administration's (HRSA) State Planning Grant (SPG) program. Several states, including California, Idaho, Maine, and Utah, legislated or implemented significant expansions in 2003.

Throughout the last several years, SCI's large demonstration grants and HRSA's one-year planning grants have enabled the states to research and implement realistic approaches for maintaining or broadening coverage during these difficult times.

Figure 1: Percentage of People without Health Insurance by State in 2002

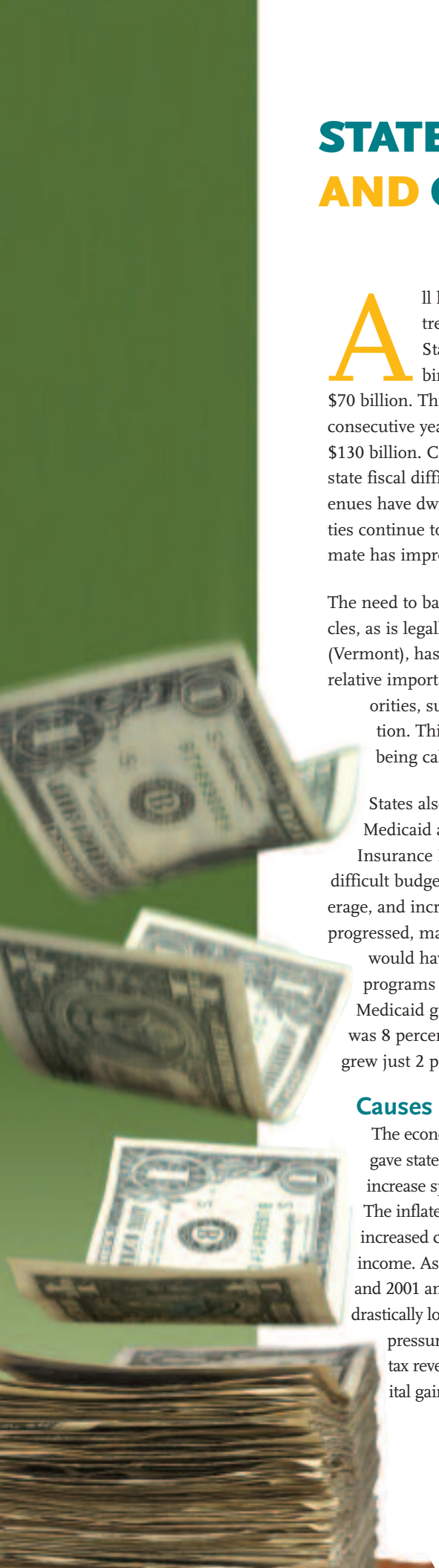


Source: Current Population Survey, Annual Demographics Survey, March 2003. http://ferret.bls.census.gov/macro/032003/health/h06_000.htm

( ) indicates change in percent from 2001-2002.

The grantee states are placing an increased emphasis on public-private partnerships, using state-specific data to support policy decisions, and interacting with the public to gain broader input into the policy process.

Although 2003 was not, by any stretch, a painless period for state governments, it has been a time for them to learn by necessity what they must do to preserve coverage. Hopefully, that knowledge will help them to emerge from the current crisis not only able to make ends meet, but to thrive.



STATE BUDGETS, COST CONTAINMENT, AND COVERAGE EFFORTS

All levels of government experienced tremendous financial strain in 2003. States were forced to tackle a combined financial shortfall of more than $70 billion. This deficit came on the heels of three consecutive years of budgets losses, each totaling $130 billion. Contributing factors to the present state fiscal difficulties are many: Overall tax revenues have dwindled, state financial responsibilities continue to grow, and the overall economic climate has improved only nominally.

The need to balance budgets despite these obstacles, as is legally required in all but one state (Vermont), has compelled legislators to debate the relative importance of health care versus other priorities, such as homeland security and education. This dire fiscal situation is rightly being called a crisis.

States also struggled in 2003 to keep Medicaid and the State Children's Health Insurance Program (SCHIP) affordable despite difficult budgetary times, greater demand for coverage, and increasing cost of services. As the year progressed, many states came to realize that they would have to restructure their entitlement programs given fast-rising costs. The average Medicaid growth rate in fiscal year (FY) 2003 was 8 percent. The Gross Domestic Product grew just 2 percent over a similar time period.

Causes of the Cost Crisis

The economic boom of the mid- to late-1990s gave states the opportunity to cut taxes, increase spending, and shore up reserve funds. The inflated stock market translated into increased capital gains, which most states tax as income. As the stock market plummeted in 2000 and 2001 and unemployment rose, states faced drastically lowered tax revenues while spending pressures increased. Since 2001, per capita tax revenue has declined 7.4 percent and capital gains have dropped 50 percent.

Because state tax codes are based in large part on the federal tax code, the tax base has only further eroded with the tax cut of 2001. The Center on Budget and Policy Priorities estimates that state revenue is likely to decline by another $3 billion over the course of two years as a direct result of changes to the federal tax code.

Continued high unemployment rates hinder state fiscal recovery. Most states depend heavily on personal income tax revenue. And with low discretionary income, people cannot afford to buy the consumer goods that yield sales tax revenue or invest in the stock market to generate capital gains. The immediate future does not look bright, and the weak economy in the states in 2003 appears to be only the tip of the iceberg. According to Leighton Ku, a senior fellow in health policy at the Center for Budget Policy and Priorities, "We won't know the full iceberg for awhile yet."

To further complicate matters, health care costs are soaring. For the third straight year, private-sector premiums rose by double digits. With an average of 14 percent hikes in their health insurance costs, many employers have increased deductibles and co-payments or discontinued benefits altogether. According to the 2002 Small Employer Health Benefits Survey, 65 percent of small employers either increased deductibles or co-payments. Of businesses surveyed, 29 percent cut back on the scope of benefits they offered. The total number of people with employer-sponsored health insurance fell by 1.3 million in 2002. Similar numbers are expected for 2003.

According to a September 30 *New York Times* interview with Kate Sullivan, director of health care policy at the United States Chamber of Commerce, "Workplace coverage is becoming unaffordable for many employers and employees." The average cost to employers rose by an average of $6,227 per employee in 2003, according to a study released by Hewitt Associates.

Figure 2: 2003 Federal Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$8,980	$11,210	$10,330
2	$12,120	$15,140	$13,940
3	$15,260	$19,070	$17,550
4	$18,400	$23,000	$21,160
5	$21,540	$26,930	$24,770
6	$24,680	$30,860	$28,380
7	$27,820	$34,790	$31,990
8	$30,960	$38,720	35,600
For each additional person, add	$3,140	$3,930	$3,610

Source: U.S. Department of Health and Human Services

These increased costs have wreaked havoc in the business and public service communities. Union contracts have stalled and workers have striked over declining employer contributions to health insurance premiums. The Los Angeles public transportation system, the third largest in the country, closed in late 2003 when transportation workers walked off the job to protest reduced health benefits.

Medicaid and SCHIP are susceptible to the same factors that drive up costs for private insurers: greater reliance on costly pharmaceuticals and rises in inpatient and outpatient utilization. In addition, more people became eligible to enroll in public programs. State-sponsored health services were demanding more money just as state budgets were being slashed to better align spending with revenue. As the second most costly item in state budgets, Medicaid and SCHIP were obliged to rein in costs.

Range of the Crisis

The degree to which states were affected by the crisis varies. Alaska faces the largest FY 2004 budget shortfall of any state, at 25 percent of its general revenue, or $500 million. Minnesota faces a $4.2 billion 2004/2005 biennial budget deficit, close to 10 percent of the state's operating budget.

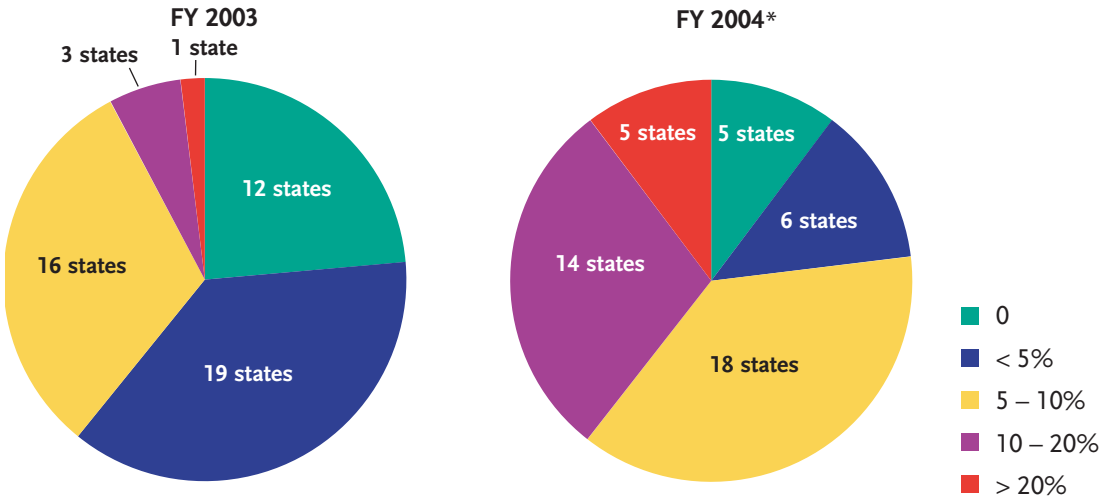
California has received the greatest news coverage about its fiscal deficit and resulting budget wrangling. About 10 percent of the state's operating budget, totaling $8.2 billion, had to be trimmed or generated in order to run a balanced budget for the 2003 fiscal year. The largest budget gap projections for FY 2004 estimate that the state is short $17.5 billion, given current spending obligations. Though a 2004 budget was technically required as of July 1, the governor and legislature were unable to come to an agreement about what to cut and how to finance the difference until August 2.

In the spring of 2003, Oregon's budget problems were so immediate—at an 18.5 percent gap—that almost 100 school districts closed in May, though five weeks remained in the school year.

Not all states found themselves in such dire circumstances: Rhode Island only needed to cut 1.4 percent of spending from its FY 2004 budget in its legislative session to remain in the black. Factors that influenced the degree to which a state was strapped financially include the extent to which the state tied its revenue stream to gains in the stock market or business sector, or how much spending grew during prosperous years. In general, the more economically developed a state, the bigger its current problems.

Figure 3: Highest Projected Budget Gaps

(as a percent of total state budget)



Source: National Conference of State Legislatures. State Budget Update: April 2003.

** Data from three states were not available for FY 2004.*

Experts agree that the current fiscal situation in states is far worse than the general economic climate would suggest. "State tax revenue has fallen far more sharply relative to the economy than in previous recessions," according to Don Boyd, director of fiscal studies at the Nelson A. Rockefeller Institute of Government. While the country appears to have retreated from its recession of 2001, states remain trapped by their poor financial forecasts.

In fall of 2003, California formalized the fiscal responsibility that employers share in their employees' health care coverage. The Health Insurance Act of 2003, signed by Gov. Davis on October 5, requires California employers to either provide health insurance coverage or pay a fee to the state. By 2007, this "pay or play" law will apply to all firms employing more than 50 people. The Center for Health Policy Research at the University of California at Los Angeles estimates that at least 860,000 workers and dependents will be directly affected by this legislation.

"The overall picture is one of modest cuts after substantial growth," says Alan Weil, director of the Assessing the New Federalism center at the Urban Institute. In other words, states have maintained their health programs to the best of their ability. They have had to cut back their programs when necessary, though the reductions are in no way proportional to the total state deficit.

State Strategies for Tackling Budget Crises

One-Time Solutions: Before the Cuts

Across the board, states have tapped various cash reserves as a first step toward patching their budget holes. The sources of these reserves vary. Alaska's cash reserve is funded because of a court settlement with oil and drilling companies. Legislators have used these funds consistently over time to balance the state's budget. According to the National Conference of State Legislatures, Alaska was short $500 million, or 25 percent of its total budget, as of April 2003. Current estimates predict that, given past spending practices, the fund will be exhausted within five years.

Iowa's cash reserve, the Senior Living Trust Fund, was created in 2000 from federal funds to expand home- and community-based services for elderly Iowans. However, Iowa has used this resource for another purpose: to offset Medicaid budget shortfalls when necessary. "There is a realization that the Senior Living Trust Fund will be empty in a couple of years," says Jennifer Vermeer, senior legislative analyst in the Iowan Legislative Fiscal Bureau. "This one-time funding source has been integral—that's why we are trying to keep it up by repaying it."

States with a rainy-day fund have saved money during good times to use when the economy takes a turn for the worse. These funds served as a one-time revenue source for many states in 2003. Stephen Moore, president of the Club for Growth,

estimated in the August 9 edition of the *National Journal* that about 25 percent of the deficit cutting in states was possible because of either borrowing or drawing down reserves.

During the 1990s, many states took advantage of massive economic growth and stockpiled rainy-day funds. At the first sign of budget difficulties, these funds seemed to provide the perfect solution. They allowed states to band-aid their budgets and stretch available resources to match spending obligations. However, this solution is short term. A sustained economic downtown will quickly drain these reserves and necessitate further state action.

By the end of 2003, rainy-day funds were largely empty in the states that chose to tap them. "We are going into '04 without a cushion," says William Wells, in the Fiscal Bureau at the South Carolina Department of Health and Human Services. "The internal cash reserves we were using are now almost gone."

Many states identified another one-time revenue source as a means of averting these unpopular measures: state income from the tobacco settlement. States had originally earmarked this money in a variety of ways, ranging from increased funding for tobacco-cessation programs to providing scholarships for college-bound state residents. But these "non-essential" programs came under scrutiny during tough budget times. Many states elected to use these funds in part or entirely to balance their tight budgets.

Having already emptied its $720 million statutory reserve fund in FY 2002, New Jersey issued bonds backed by future tobacco settlement earnings—turning what had been a yearly stream of revenue into one lump-sum payout. This amount, totaling approximately $1 billion, was described as the least painful solution to the state's 4.7 percent budget deficit. New Jersey was not alone in securitizing all or part of its tobacco settlement. Utah used $12.5 million from its settlement in order to restore dental coverage to children under SCHIP. In total, at least 17 states or counties, including California and Washington, borrowed from or spent portions of their tobacco settlement.

States maximized whatever revenue streams they could. Increased sin taxes were common. West Virginia increased their cigarette tax to 55 cents a pack. This will raise an estimated $60 million for the state to use to draw a three-to-one match ($240 million) in federal Medicaid funds. Michigan, on the other hand, hurried its tax collection in order to increase revenue. Specifically, the state collected property taxes twice in a single fiscal year.

Minimizing Outlays

Going into a third year of financial shortfalls, many states had already spent their cash reserves. States could no longer match income to spending by boosting revenue at the state's disposal. How else might a state reach a balanced budget without changing its spending habits? Many states have used a strategy of stalling their debt in order to pass through the budgetary process.

One common method of matching inputs to outlays is to minimize the amount that must be paid out. In other words, delayed debt looks on paper like minimized expense. Many states fiddled with their accounting standards in order to reduce their immediate spending obligations. By changing the due date of bills or the method of charge accrual, states were able to postpone current expenses into the next budget cycle. Colorado expects to save $77 million in claims by changing their six-month charge period. New Jersey delayed payments to schools until July 1, 2003, saving the FY 2003 budget $300 million.

Recent cost-containment efforts have largely targeted pharmaceutical spending. The prescription drug market in the United States totaled more than $140 billion in 2001. One-tenth of all health care dollars are spent on pharmaceuticals. According to the Kaiser Family Foundation, 45 states have implemented or proposed strategies for reducing pharmaceutical costs as of FY 2003.

Kentucky expects their preferred drug list to save the state $81 million in 2004. Michigan hopes that multi-state bargaining will leverage better prices from drug providers. Ohio has tried to create an incentive for long-term care pharmacies to develop strategies for cost-effective drug use in the long-term care setting. Pharmacies that are successful in lowering costs will then partake in the savings.

The governors of Illinois, Iowa, Minnesota, and Wisconsin have expressed interest in importing cheaper drugs from Canada, thus saving state budgets millions of dollars. Tom Scully, former

The Center for Evidence-Based Policy aims to be a bridge between research and policy. Few states, particularly in the current economic environment, have the resources to conduct evidence-based drug reviews on their own, or the expertise to sort through an overwhelming amount of technical research.

Evidence-Based Drug Reviews: New Oregon Center Shares the Wealth

A new center at Oregon Health and Science University will soon allow multiple states to use evidence-based drug class reviews, which were begun in Oregon in 2001, to help keep their Medicaid pharmaceutical costs in check. If a "critical mass" of 15 states agree to pay about $100,000 each, the Center for Evidence-Based Policy will be up and running, according to the new Center's Director and former Oregon Governor John Kitzhaber. John Santa, the Center's new assistant director for health care projects, says that interested states are in the final contracting stages.

In 2001, the Oregon legislature and then-Gov. Kitzhaber signed S.B. 819 into law. It required the formation of the Practitioner Managed Prescription Drug Plan (PMPDP) to "ensure that enrollees of the Oregon Health Plan receive the most effective prescription drugs available at the best possible price." The plan authorized the state to make drug-effectiveness determinations in order to compile a list of drugs that the state's Medicaid program would cover.

Unless a doctor specifies an exception, the Oregon Health Plan only pays for drugs included on the list. Since its formation, the PMPDP has reviewed 12 drug classes, including estrogen, cholesterol-lowering drugs, and beta blockers. A full list of the reviewed drug classes is available at www.oregonrx.org.

A few states have worked with Oregon to share in their research, and the new Center will formalize that relationship. It will also extend the opportunity to many more states. Each participating state will contract with the Center for commissioned reviews of up to 25 drug classes, with six-month updates.

Private groups may also contract with the state, but the Center anticipates that most of its clients will be state Medicaid programs. In hopes that the evidence will be used internationally, it has adopted the slogan: "Globalizing the Evidence, Localizing the Decision," which was coined by Carolyn Clancy, M.D., director of the Agency for Healthcare Research and Quality.

The Center aims to be a bridge between research and policy. Few states, particularly in the current economic environment, have the resources to conduct such reviews on their own, or the expertise to sort through an overwhelming amount of technical research.

Some states are hoping that they can publicize the analyses in an effort to counter the effects of direct-to-consumer advertising by pharmaceutical companies. Interested states are pursuing further cost savings by contacting the Centers for Medicare and Medicaid Services to determine whether they will receive a Medicaid match on their payments to the Center if they apply the data to their Medicaid programs.

director of the Centers for Medicare and Medicaid Services, was quoted July 1 by National Public Radio, saying, "States have every right to operate just like General Motors or General Electric and use their market power to get the best prices they can for their Medicaid populations."

Subtle Cuts

Lee Dixon, director of the National Conference of State Legislatures Health Policy Tracking Service, describes two state cost-cutting trends in an August 9 article in *National Journal*: "hard" cuts and "subtle" cuts. Hard cuts are direct reductions to programs or benefits, while subtle cuts are policy changes that have a stated aim other than cost containment but nevertheless result in money saved.

On the surface, subtle cuts may have an innocuous goal or a politically marketable aim. They have secondary objectives, however, of helping a state balance its budget. Among the subtle cuts that have been particularly popular in 2003 are curtailed outreach funding and fraud prevention.

Outreach efforts have suffered in the poor budget climate. "It is hard to stomach funding outreach when we are at the point of needing to cut people from programs," says Beth Fife, chief of California's Medi-Cal Eligibility Branch. California has eliminated its funding of Certified Application Assistants (CAA).

In the past, CAAs earned $50 for each applicant they successfully enrolled in either Medicaid or SCHIP. Eliminating public financing of these positions will directly save the state $7.1 million for FY 2003. In addition, fewer eligible people will find their way into public-assistance programs, further saving money for the state. Two-thirds of those enrolled in public programs used the services of a CAA.

States have also looked to fraud-prevention mechanisms for cost containment. In pursuit of this aim, many states have mandated that beneficiaries prove more often that they are in fact eligible for the services that they receive. In 2003, Connecticut eliminated its continuous 12-month eligibility standard. Beneficiaries are now required to reapply for Medicaid and SCHIP whenever their household income changes. The state expects $3.9 million in direct savings from this. The state also estimates that 1,800 cases, both parents and children, will lose coverage over a full-year period.

Many of these people are not losing their coverage due to loss of eligibility, but rather because they must jump through more hurdles in order to retain their coverage. "Cumbersome procedures increase red tape and paperwork, delay access to care for children with medical needs, and complicate enrollment," according to a representative from the Children's Health Council, a Connecticut advocacy group. In implementing these rules, the state in effect saves money. Framing the strategy as one that prevents fraud and system abuse offers a more palatable way to cut people from the rolls.

Structure Cuts

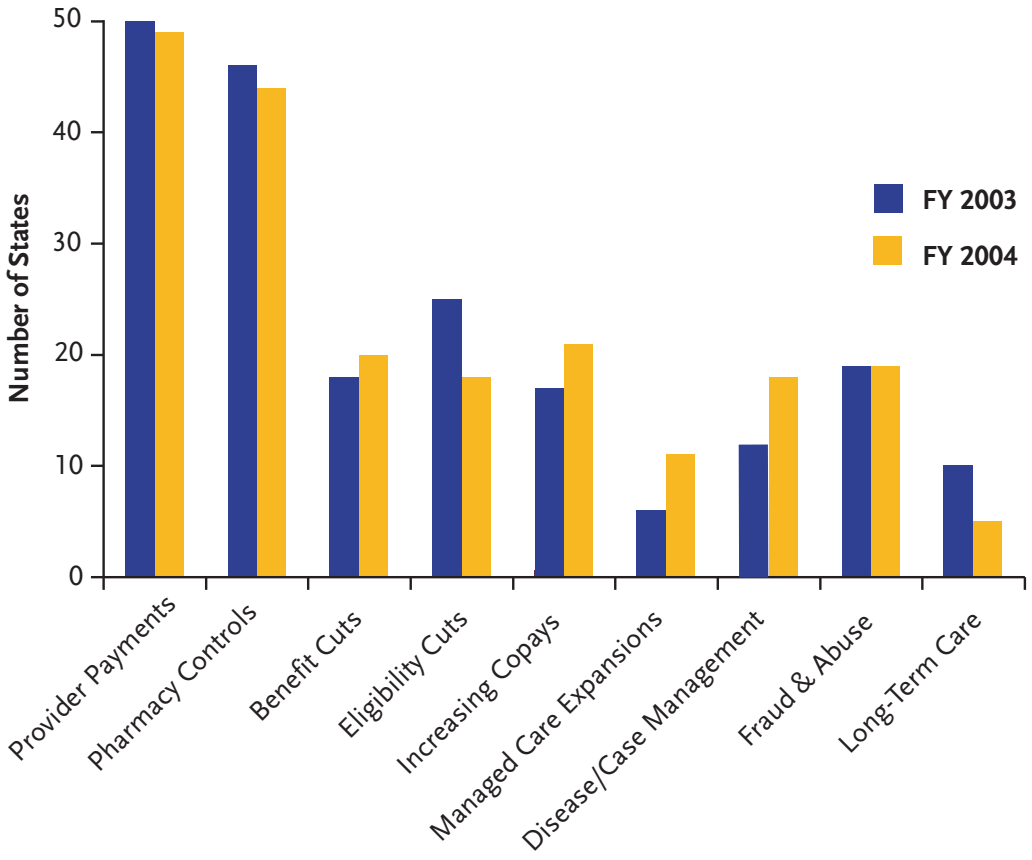
The severity of the states' budget problems often forced them to reduce Medicaid eligibility and limit benefit coverage. Indeed, many states felt they had little choice but to cut the programs they offer. According to the Kaiser Commission on Medicaid and the Uninsured, in 2003, at least 29 states have considered reducing or eliminated coverage and 18 states have reduced available benefits.

Overall program reductions are typically at the expense of optional services or populations. States have broad discretion in deciding what people or services they will cover. The federal government outlines a basic set of requirements that states must follow in order to be eligible for their matching funds. Beyond these requirements, states may tailor their Medicaid and SCHIP programs to match their needs.

In 2003, 25 states reduced eligibility levels for Medicaid programs. These cuts primarily affected well-defined adult enrollees. To target these populations, states slightly reduced qualifying income levels, restricted transitional medical assistance, or dropped specific populations altogether. Though these changes affect a broad spectrum of beneficiaries, parents of eligible children were at most risk for losing coverage.

Missouri dropped its income standard for Medicaid eligibility from 100 to 77 percent of the federal poverty level (FPL), eliminating more than 32,000 people from its Medicaid rolls. Colorado cut coverage for approximately 3,500 legal immigrants. Oklahoma eliminated its medically needy program, which had allowed individuals with high medical costs relative to income to qualify for Medicaid.

Figure 4: State Cost-Containment Actions



Data pulled from Kaiser Commission on Medicaid and the Uninsured: September 2003.
States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004

Eighteen states restructured their benefits packages in 2003. According to officials in Ohio, all optional services were on the chopping block. All non-emergent services and therapy options were threatened, although changes in benefit packages tended to be rather narrowly focused. Benefit reductions primarily targeted the adult population, including seniors and the disabled. Nine states restricted adult dental coverage, and six partially or fully reduced reimbursement for vision care.

Nebraska limited the access of 1,800 children to orthodontic care by only allowing treatment for severe conditions. Florida estimates that it can save $2.3 million by not covering circumcision services. More than 14,000 people will be affected by this change. Bruce Goldberg, administrator of the Office for Oregon Health Policy and Research, equated cutting optional benefits "with walking a fine line between the need for money and the need for services." Just because the state cannot afford to provide certain benefits doesn't mean that people do not require them.

Several states used federal waivers to fully restructure their benefit packages. These waivers permit more flexibility, allowing states to change services to populations otherwise considered mandatory.

Oregon submitted a letter to the Secretary of Health and Human Services requesting more leeway to save the Oregon Health Plan (OHP). The state outlined a plan to cover the same populations, but change the benefit package. At the time that this publication went to press, the state was still in negotiations with CMS about the waiver.

The "OHP Standard" population, low-income adults earning incomes up to 100 percent FPL, would be subject to a reduced benefit plan and higher cost sharing. They would be restricted from using all non-emergent hospital services, therapies, and home health care. Though optional services are limited, the OHP Standard population might still access mental health coverage, chemical dependency programs, and emergency dental care. Oregon also sought federal approval to reduce the number of covered services on its prioritized list, which the state uses to determine which serv-

ices it will cover. "The state could prioritize either population or benefits, but not both," says Bruce Goldberg. "The future of the OHP was in doubt."

Many states implemented increased cost sharing in 2003, requiring beneficiaries to pay deductibles, premiums, or co-payments to constrain the total amount of services used.

Connecticut implemented $1 co-payments for all outpatient services and prescription drugs as of July 1. It is expected that this will increase over time to the federally allowed maximum. State law maintains that patients cannot be refused service because they cannot afford a co-payment. As such, cost liability will shift from patients to pharmacies and service providers. The state "understands that this may put a strain on the system," according to Steve Netkin in Connecticut's Office of Policy and Management.

Federal Aid: A Ray of Sunshine

Among the good news in 2003 was the enactment of the federal Jobs and Growth Relief Reconciliation Act in June. It provided states with a possible $20 billion in fiscal relief. Half of this money became available to states through a temporary increase in the federal matching rate for Medicaid programs. The legislation offered another $10 billion in grant money for use toward state programs, including Medicaid. To be eligible for this money, states are required to maintain the same eligibility levels they had in September 2003.

This state aid is intended to be flexible, so that states might address their own particular Medicaid and total budget shortfalls in FY 2003 and FY 2004. How the states spent their money depended on where they were in their budget process when the funds came through. States on the verge of passing a budget were able to save some services with the funds in last-minute negotiations, while those far from completing a budget used the federal bailout as a one-time revenue source.

In any case, the money proved to be invaluable. "The federal money is already spent," says Fife of California's Medi-Cal Eligibility Branch. "It was used in total to balance the budget." Although the funds didn't allow the state to avoid cuts, says Fife, it guaranteed that there would be fewer of them. Other states were able to use the fiscal relief in order to save services or benefits previously eliminated. Nico Gomez, public information officer in the state of Oklahoma, described these funds as "a ray of sunshine in an otherwise stormy budget period."

Coverage Expansions and Access Improvements

While most states worked hard in 2003 just to maintain their health services, a few were able to expand their coverage. Illinois successfully expanded its SCHIP program. At a cost of $25.8 million, the state raised income limitations for children to 200 percent FPL and for parents to 90 percent FPL. Wyoming increased its funding to Medicaid by $42 million, providing coverage to an additional 8,000 beneficiaries.

Idaho extended SCHIP coverage to families with incomes between 150 and 185 percent FPL. Children in these families will now have access to either a reduced benefit plan or a $100 monthly subsidy for insurance. In June 2003, Governor John Baldacci (D-Maine) signed the Dirigo Health Plan into Maine law. The program combines a subsidized private plan and a Medicaid expansion with the intent of covering all Mainers by 2009. (For more information, see box on page 12.)

Many states that were forced to downsize health care spending bolstered the system where they could—by strengthening the safety net in order to maintain access to care and prevent future state expense. New Jersey sent an additional $10 million to the Department of Public Health. This money was earmarked for establishing community health centers in underserved counties.

Ruth Charbonneau, director of the New Jersey State Department of Health and Senior Services, described the effort as "a strategy for creating a safety net for the working poor." Montana doubled its appropriations to the Department of Public Health, expecting the federal government to match the amount. Though Texas cut SCHIP funding for 2004 by $299 million, it increased funding to trauma centers by $1 billion over five years.

Conclusion

In general, the outlook for states remains poor. According to Paul Cooper, staff assistant in Kentucky's Commissioner's Office, the state expects next year to be difficult again. At the same time, many states will face additional pressures in the future because of the manner in which they closed their budget gaps. "They may have pushed part of the problem into 2005 and beyond," says Weil of the Urban Institute. Nevertheless, states will continue to struggle to maintain coverage, access, availability, and affordability of care.

Dirigo translates to "I lead" in Latin. Under the program, Maine aims to provide coverage to 180,000 state residents, specifically small-business employees and the self-employed.

Dirigo Health: Maine Plans Ambitious Expansion

With so many states having to scale back their public programs in light of the weak economy, it's nice to know that the word "expansion" hasn't disappeared from all states' vocabularies. Probably the most ambitious proposal to come out of a state in several years is Maine's Dirigo Health Plan. The program—which passed the Maine legislature in June 2003—combines a subsidized private plan and a Medicaid expansion with the intent of covering all Mainers by 2009.

Under Dirigo, which translates to "I lead" in Latin, Maine aims to provide coverage to 180,000 state residents, specifically small-business employees and the self-employed. The bill, which was signed into law by Governor John Baldacci (D), had unanimous, bipartisan support from the Joint Select Committee on Health Care Reform and passed through both chambers of the state legislature with a two-thirds majority. The plan was conceived with three guiding principles: that access to care should be universal, that all people deserve high quality care, and that total costs must be reduced.

Indeed, the creation of Dirigo was primarily motivated by dramatic increases in costs. In the last decade, health care costs grew more rapidly in Maine than in any other state. Small business endured a 58 percent increase in insurance premiums since 1996.

The Dirigo Health Plan includes a two-prong coverage expansion. First, the state has pledged to expand MaineCare, the state's Medicaid and State Children's Health Insurance Program. Parents with incomes up to 200 percent of the federal poverty level (FPL) and non-categoricals earning less than 125 percent FPL will be eligible. Second, Dirigo will establish a public/private health plan. Businesses of 2 to 50 employees, the self-employed, and unemployed or part-time workers can select this insurance product.

Dirigo will provide subsidies according to a sliding-fee schedule to enrolled individuals and families based on their ability to pay. Employers who elect to offer this product to their employees and pay at least 60 percent of its cost will benefit from lower rates as a result of better risk pooling.

Through the public/private partnership, Maine officials will establish a benefit package that private insurance carriers will provide. If no carrier is willing to participate in the program, the state will stand in as the insurance provider of last resort. The benefit package will be comprehensive and will focus on prevention and disease management.

Successful implementation of Dirigo will require all stakeholders to make some concessions. Program development was an extremely public process. All parties negotiated extensively with the governor and consulted with his panel of health care experts, including Trish Riley, former executive director of the Center for Health Policy Development at the National Academy for State Health Policy. According to Riley, Dirigo Health became reality because Gov. Baldacci was willing to make it his first priority.

To make Dirigo financially viable, Maine must contain costs. The state plans to create a publicly funded purchasing pool through which it can better negotiate prices. "About 500,000 Maine citizens receive health benefits through public-sector programs and employment funded by state and local tax dollars," said Riley in the September 22 issue of *Health and Medicine Week*. "By better coordinating all these disparate programs Maine can be a more prudent buyer of health care and save taxpayers money in the long run."

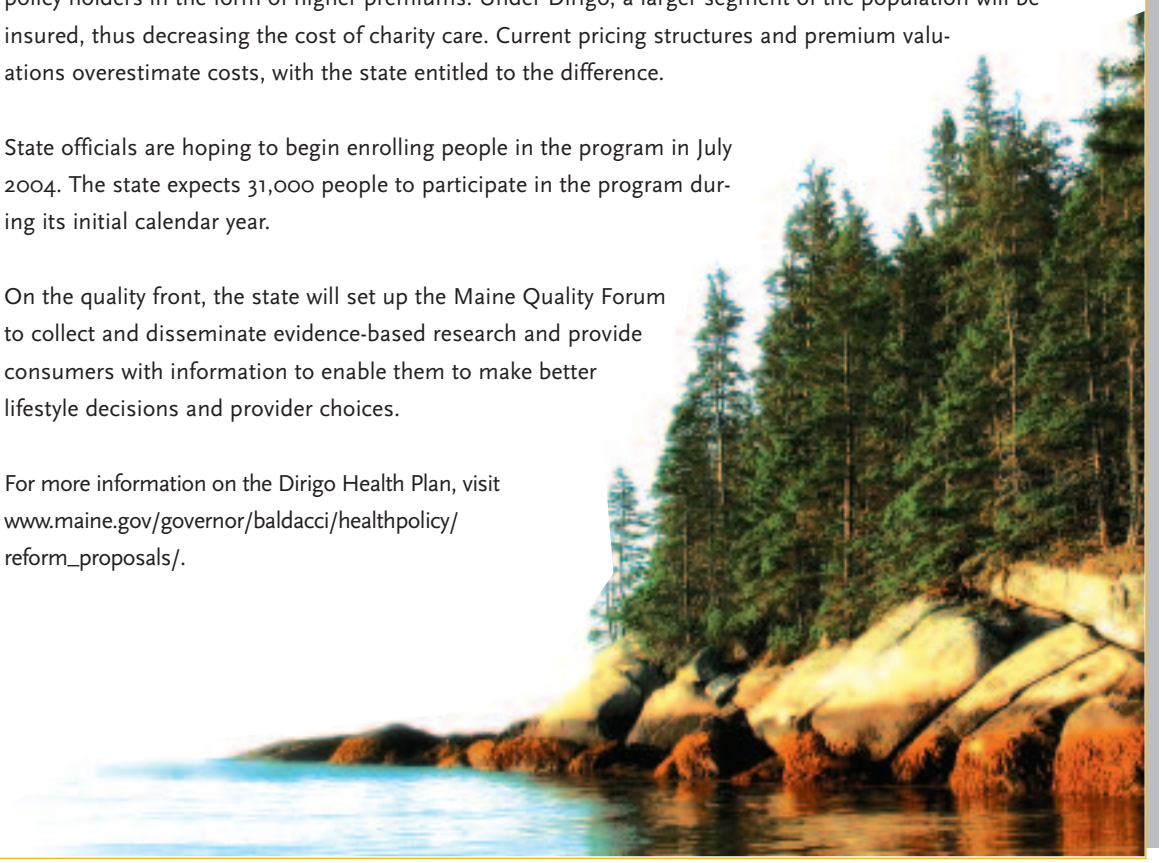
Maine officials will take a number of approaches to finance the expansion, including using $53 million in state funds to jump-start the program. It will also gain more in federal match funds by expanding its Medicaid program. The state has urged hospitals, physicians, and carriers to voluntarily limit their net revenue or charge increases in excess of 3 percent annually. It will retroactively charge insurance companies a 4 percent annual fee per patient covered.

This "savings offset payment" is the most interesting—and perhaps controversial—component of the funding scheme. The state's reasoning is that the fee represents the cost of charity care. Hospitals currently pass the cost of charity care onto insurers by pricing services at a higher rate. Insurers then pass that cost onto policy holders in the form of higher premiums. Under Dirigo, a larger segment of the population will be insured, thus decreasing the cost of charity care. Current pricing structures and premium valuations overestimate costs, with the state entitled to the difference.

State officials are hoping to begin enrolling people in the program in July 2004. The state expects 31,000 people to participate in the program during its initial calendar year.

On the quality front, the state will set up the Maine Quality Forum to collect and disseminate evidence-based research and provide consumers with information to enable them to make better lifestyle decisions and provider choices.

For more information on the Dirigo Health Plan, visit www.maine.gov/governor/baldacci/healthpolicy/reform_proposals/.



Maine will use $53 million in state funds to jump-start Dirigo Health. The state will also gain more in federal match funds by expanding its Medicaid program.

HEALTH CARE AS A NATIONAL ISSUE

In 2003, health care reemerged as a major national issue. As in the early 1990s, health care inflation and a weakened economy underlay many Americans' anxiety about keeping their health insurance coverage. With states facing their worst budget crises since World War II, their challenges in 2003 were daunting, and the tension between states and the federal government on health care financing issues was as palpable as ever.

Yet despite the national recession and competing federal priorities such as defense and homeland security, in 2003 the federal government engaged in serious discussions about restructuring public health care programs. Of course, the biggest health reform news of 2003 came in late November, when Congress finally passed a bill to modernize Medicare and establish a prescription drug program for seniors covered under the program. The historic legislation marked the first major improvement to Medicare since the program's inception in 1965.

Meanwhile, as the 2004 Democratic presidential candidates tried to identify with the aging U.S. population—who rank health care high among their personal priorities. Proposals to achieve universal coverage began to circulate at the federal level for the first time since the failure of the Clinton plan in the early 1990s.

The Plans

The Democratic presidential candidates offered reform proposals to address the flaws in the American health care system, especially the growing problem of the uninsured. "The state of the economy and the relationship between the cost of care and what's happened to the uninsured will be addressed in the 2004 campaign cycle, because it's what people care about," says Bill McInturff of Public Opinion Strategies, a political and public affairs survey research firm.

In a September poll conducted by McInturff, 51 percent of respondents who identified themselves as Democrats said that health care will be extremely important to their vote in 2004. The candidates wasted no time outlining their solutions and attempting to sell them to the American public.

The candidates take different approaches to expanding coverage—but nearly all would finance their plans by repealing President Bush's tax cuts. Their price tags vary significantly as well, depending on how ambitious their goals are.

"Generally speaking, proposals that get you to, or close to, universal coverage have a larger price tag," says Jack Meyer, president of the Economic and Social Research Institute. That's why Ohio Representative Dennis Kucinich's plan, which aims to provide universal coverage, carries the largest price tag, at $6 trillion over 10 years. He advocates a single-payer system through an expansion of Medicare to all citizens. Carol Moseley-Braun also favors a single-payer system.

Five of the proposals—from Retired General Wesley Clark, former Governor Howard Dean, Senator John Edwards, Senator John Kerry, and Senator Joe Lieberman—contain flexibility to cover the majority of the uninsured in an incremental way. They would each build on Medicaid and the State Children's Health Insurance Program (SCHIP). These candidates envision a world where all low-income children and adults (defined by a certain level of poverty) are eligible for one of these government programs. (For more information on the candidates' proposals, see www.statecoverage.net/options.htm.)

Dean was among the first to put forth a proposal. His plan would establish a Universal Health Benefits Program (UHBP) requiring insurers that offer health plans to federal employees to offer the same plans to individuals not covered by the new Family and Children Health Insurance Program, Medicaid, or Medicare. Tax credits equal to the difference between the UHBP premi-

Figure 5: Comparison of Major Health Care Reform Proposals

	Bush*	Clark	Dean	Edwards	Gephardt	Kerry	Kucinich	Lieberman
Coverage for All Americans		X	X		X	X	X	X
Tax Credits for Premiums	X	X	X	X	X	X		X
Automatic Enrollment/ Individual Mandate		X	X	X			X	
Employer Mandates, Incentives or Penalties			X	X	X			X
New Group Option for Small Firms, Individuals		X	X	X		X		X
Low-Income Public Expansion		X	X	X	X	X	X	X
Medicare Buy-In for Older Adults				X	X			

As of November 17, 2003

* The Bush proposal is his FY 2004 budget proposal, not part of his campaign platform. Other policies may be forthcoming.

Source: The Commonwealth Fund.

um and 7.5 percent of the taxpayer's income would help make coverage affordable. The proposal would require employers to continue paying their share of the premium for a covered worker for two months after he or she leaves a job.

Both Kerry's and Lieberman's proposals contain strategies to control costs. These include promoting and implementing new technologies, providing financial incentives for providers and purchasers, and encouraging disease management programs.

Kerry would also establish a new group insurance option, called the Congressional Health Plan, based on the Federal Employees Health Benefits Program. It would be open to large and small employers as well as to individuals. However, perhaps most important in Kerry's plan is his proposed "swap": The federal government would foot the entire bill for all Medicaid children, while the states would fully finance an expanded SCHIP program reaching up to 300 percent of the federal poverty level (FPL) and open it up to parents of these children.

"These proposals represent a big change for states," says Meyer. "In the short term, states would have to pony up their share of money to implement these expansions." Although the plans would likely generate some offsetting savings over time, the candidates really can't eliminate the need to make an initial financial obligation.

Clark, who was the last candidate to reveal a proposal, would use money raised from his economic plan and the extra revenue generated from his job creation plan to improve the system. To that end, he plans to do three things: focus on preventive care, cover all children, and make insurance affordable and portable.

Gephardt's plan involves some new spending by states, but for the most part requires a larger federal investment. Calling access to health care the "moral issue of our time," Gephardt proposes a 60 percent tax credit to employers for the cost of health care, which would extend coverage to 27.5 million currently uninsured Americans in working families. His plan would also extend coverage to 2.2 million more children and their parents by expanding eligibility for SCHIP and enrolling more eligibles.

"There's one difference in 2004 compared to prior elections—these Democrats will not be as vulnerable to the charge that they're turning the system upside down," says Meyer. "They can counter with: 'Well, our price tag may be bigger than yours, but we're accomplishing much more while still working through the existing health care system.'"

Incrementalism Still Dominant

Compared with the ambitious proposals outlined by many Democratic candidates, proposals intro-

"Today health care is an economic issue, not just a health care issue," says Democratic pollster Celinda Lake. That might explain why it appeared on the front pages of many newspapers and in broadcast storylines throughout much of the fall of 2003.

Health Care in the News

Health care has traditionally been one of the premier social issues that generates a flurry of news coverage. In 2003, it proved once again to be a locus of intense public debate. Congress appeared ready to tackle Medicare reform, the U.S. Census Bureau released new data that showed a growing uninsured population, and a presidential election was only a year away.

"Today health care is an economic issue, not just a health care issue," says Democratic pollster Celinda Lake. That might explain why it appeared on the front pages of many newspapers and in broadcast storylines throughout much of the fall of 2003. Employees are bracing once again for a double-digit increase in their health care premiums, while cost-of-living increases pale in comparison.

Census: More Americans Are Losing Coverage

On September 30, the front pages of *The New York Times, The Wall Street Journal,* and *The Washington Post* all delivered the bad news from the Census: The number of Americans lacking health insurance climbed by 5.7 percent in 2002, to 43.6 million—the largest single increase in a decade. Diane Rowland, vice president of the Kaiser Family Foundation and executive director of the Kaiser Commission on Medicaid and the Uninsured, testified before Congress on the fragile state of American health care.

"The Census data reveal that the uninsured are not only a large problem, but a growing problem for millions of Americans," said Rowland. "The rise in the number of Americans without coverage should be of concern to all of us because health insurance makes a difference in how people access the health care system, and, ultimately, their health." (See box on Cover the Uninsured Week, page 32.)

Problems with health care also weaved their way into the evening news. In October, ABC News featured "Critical Condition: Health Care in America," a weeklong series of reports that looked at everything from employers dropping coverage to health coverage disputes to the rising cost of care. The week kicked off with a poll, conducted jointly by ABC News and *The Washington Post*, on Americans' attitudes toward the health care system, which found "broad, and in some cases growing, discontent with the U.S. health care system."

Many of the segments featured Americans telling stories about the problems they encountered with the health care system—including coverage denials, cost issues, and the experience of being uninsured. Such personal narratives really resonate with the American public, says Lake.

And the cost of care is clearly a theme to which all Americans can relate. "We're on the absolute cusp of major change in health care, and it's driven by one factor: costs," according to Brent Layton of the health care consulting firm Layton & Associates.

Unions, Associations Lend Voice to Health Care Debate

For their part, the presidential hopefuls made sure that voters knew that health care was a priority. Each candidate drafted comprehensive proposals to "fix" the system, which they touted in stump speeches across the country and on their Web sites. But they weren't the only ones speaking out on the issue.

Several unions and associations put forth their positions to make it clear to candidates that their commitment to health care would be a critical factor in gaining their vote in 2004. Many of them launched individual campaigns and set up Web sites to inform their constituents about the candidates and their positions on health care.

In September, the Service Employees International Union's "Americans for Health Care" campaign released the first issue ads of the 2004 election cycle in Iowa and New Hampshire. Whenever presidential candidates stepped off the plane at the Manchester, Des Moines, and Cedar Rapids airports, they saw billboards featuring local nurses demanding: "Running for President? Health care better be your priority."

"It's time for every one of these candidates to get the message that people all over this country are ready for realistic solutions to the health care crisis," says SEIU President Andy Stern. "People want to know what candidates are going to do and how they're going to pay for it—and they're going to cast their votes around this issue."

"People want to know what candidates are going to do around the health care issue and how they're going to pay for it."

– Andy Stern, SEIU

"Don't Come Home Without It"

Reminding lawmakers to pass a prescription drug benefit under Medicare this year was the focus of the Alliance to Improve Medicare's (AIM) "Seniors are Waiting" campaign. AIM, a coalition of major employer organizations, health care plans and providers, and senior citizen alliances, launched the campaign in September using television, print, and radio advertising in Washington, D.C., and strategically important states and congressional districts throughout the country. The ads featured senior citizens telling their members of Congress they have waited long enough for a better Medicare program and prescription drug coverage.

"The Seniors Are Waiting" campaign was designed to remind lawmakers to finally deliver on prescription drug coverage and provide more choices under Medicare.

"I view this campaign as a gentle nudge to members of Congress to do what they know is right and necessary," says Mary R. Grealy, president of the Healthcare Leadership Council.

"These ads simply reinforce what we hear from seniors at the grassroots level nationwide: Congress should get it done this year," says Karen Ignagni, president and CEO of the American Association of Health Plans. And they did. In November, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. (See page 22 for more information.)

AARP ran a similar cluster of ads on the need for prescription drug coverage under Medicare, which featured average Americans convincing lawmakers to pass the provision. "If you could do it alone," they posit, "you wouldn't need AARP."

Some predict that the health care issue will get more and more attention as next year's presidential election approaches, just as it did in 1991 and 1992. "I think that we're seeing something that we saw in the early 1990s, which is the confluence of high cost, an unstable private insurance market, people's concern about their care, and what they perceive to be a weakened economy," said Bill McInturff of Public Opinion Strategies at an October 2003 briefing sponsored by the Alliance for Health Reform. "Every time those conditions come together we have had a major debate about health care in this country."

duced by President Bush and other lawmakers were modest. The more incremental reforms may be the current strategy of choice for a number of reasons, including the failure of earlier far-reaching attempts to reform the system and a lack of federal money to fund various initiatives.

President Bush's incremental approach, which builds largely on the individual insurance market, would cost $89 billion over 10 years and insure an estimated three to six million people without coverage. This appropriation was part of the President's Fiscal Year (FY) 2004 budget proposal, not his campaign platform.

According to Tommy Thompson, in 2003, the President called on Congress to apply the lessons of SCHIP to the entire Medicaid system. However, the proposal's offer of greater flexibility came at the cost of shifting greater financial risk to the states.

Bush's approach is three-fold. It will: 1) give refundable tax credits to individuals to use in the non-group market or for employer-sponsored coverage; 2) grant additional regulatory flexibility to states to expand coverage; and 3) double existing funding for community health centers.

States would benefit from more community health centers, says Meyer, because such institutions would strengthen the safety net and reduce state spending on the uninsured using federal dollars.

New Roles for State and Federal Financing

In 2003, there were serious discussions about how to substantially restructure existing public programs, particularly Medicare and Medicaid, and the roles and responsibilities the states and the federal government would assume.

As states consider the implications of such changes, they must balance the financial burden associated with any new restructuring with potential long-term savings. "No plan is a free ride for states," says Meyer. While the proposals offer additional federal funding, clearly states will continue to be important financiers of health care.

Medicaid

At the outset of 2003, Secretary of the U.S. Department of Health and Human Services (HHS) Tommy Thompson unveiled a new proposal for Medicaid reform on behalf of the Bush administration. The ensuing discussions highlighted the tension between the federal government and states, particularly in times of fiscal stress, over who should assume the lion's share of responsibility for covering low-income Americans.

The administration's proposal included a new financing mechanism for Medicaid—block grants—that is intended to modernize Medicaid rules and provide more flexibility for states to administer their programs. The administration's plan for Medicaid reform was modeled after SCHIP.

"SCHIP allows states to utilize federal support in ways that make sense for them," said Thompson in the spring issue of the Council of State Governments *Spectrum*. "Their expenditures are not straitjacketed by inflexible national rules; rather, states are empowered to do what's best for their residents."

According to Thompson, in 2003, the President called on Congress to apply the lessons of SCHIP to the entire Medicaid system. However, the proposal's offer of greater flexibility came at the cost of shifting greater financial risk to the states.

The lure of the administration's proposal was how it addressed the states' immediate fiscal problems. States could receive an additional $3.25 billion in new money for FY 2004 and $8.9 billion over five years; $12.7 billion would be allotted for the first seven years of the program. However, states electing to receive this federal relief now would have to fund their Medicaid programs through block grants.

Thus, instead of the federal government sharing Medicaid costs through the existing open-ended financing system, states would receive capped allotments for acute and long-term care. These two funding streams would replace what states currently receive as federal matching funds for Medicaid services, SCHIP services, Disproportionate Share Hospitals (DSH) payments, and administrative expenses. States choosing not to participate would continue to operate their program under the existing Medicaid rules and funding.

The administration sought the governors' support for the proposal to guide the process and craft the details that had not been developed. The governors had declined endorsement of the proposal at the National Governors Association (NGA) winter meeting. Instead, the NGA formed a bipartisan Medicaid Task Force "to work with Congress and the administration to fashion a mutually acceptable proposal." Members of the Task Force included governors from Connecticut (R), Florida (R), Idaho (R), Indiana (D), Iowa (D), Kentucky (D), Maryland (R), Missouri (D), New Mexico (D), and North Dakota (R).

After several weeks of deliberation, the Task Force identified six priority issues for Medicaid reform: 1) increased flexibility in administering the program without requiring waiver approval; 2) prescription drugs; 3) long-term care costs; 4) public-private partnerships; 5) financing; and 6) dual eligibles (individuals who qualify for both Medicare and Medicaid).

By early June, bipartisan efforts to craft a Medicaid reform proposal had broken down. The Task Force could not agree on a financing system that could be supported by both the Democratic and Republican governors.

However, bipartisan agreement never wavered on certain issues. As noted earlier, states have long advocated for greater flexibility for administration and design of their Medicaid programs. Likewise, there has never been partisan contention about the issue of dual eligibles; all Task Force members strongly agreed that the federal government should finance health care for these individuals.

"The single issue that the task force members came to consensus on very quickly, very strongly, and across party lines, was that the states had no business bailing out the Medicare program," says Matt Salo, chief health lobbyist for the NGA and the association's lead on the Task Force.

Dual Eligibles a Critical Issue for States

The issue of dual eligibles has been an area of concern for states for some time. Although this group constitutes 19 percent (6.2 million) of all Medicaid beneficiaries, they account for nearly 39 percent of all Medicaid spending, and about half of all Medicaid prescription drug expenditures. State budget crises and efforts to contain costs brought the dual-eligible population to the forefront of policy discussions in 2003.

An older and often disabled population, dual eligibles tend to have chronic conditions and much higher medical expenditures. State Medicaid programs, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs, pay for some or all of dual eligibles' Medicare benefits, depending on beneficiaries' incomes and resources. Those with incomes that are too low to qualify for the QMB, SLMB, or QI programs qualify for full Medicaid benefits, which state Medicaid programs pay for as well.

Much of the rising costs in Medicaid programs can be attributed to prescription drug spending by dual eligibles. Though not a mandatory part of Medicaid programs, prescription drug coverage is voluntarily included by all states in their Medicaid benefit packages. Thus, when dual eligibles are enrolled in Medicare, which historically had not contributed for coverage of prescription drugs, Medicaid offers this $16 billion a year benefit as part of its "wrap-around" coverage. Task force members made strong appeals to the administration to consider federalizing the costs of this group under Medicare.

Medicare

As the policy window closed for significant Medicaid reform in 2003, it clearly opened for Medicare. Enacted in 1965, the Medicare program covers adults over the age of 65. For the past 39 years, the Medicare benefits package only covered the cost of prescription drugs given in inpatient facilities or those that beneficiaries cannot administer on their own. The lack of an outpatient prescription drug benefit has been a major source of public outcry and partisan bickering for the past four decades.

The first legislative attempt to address the issue was raised in Congress in 1988 with the passage of the Medicare Catastrophic Coverage Act. However, the legislation was repealed before it could be implemented. Other proposals have been introduced since then, particularly in the past few years, with no success. In June 2003, the Senate and House passed two differing proposals—S.B. 1 and H.B. 1—to establish an outpatient Medicare drug plan.

The following six months, during which the legislation was in conference, constituted a contentious and politically challenging period. Many experts watching the negotiations felt certain that a compromise would never be reached. The process of finding common ground between the House and Senate bills required arduous negotiations by the Conference Committee.

In addition to the outpatient prescription drug provision on the table, there were several other major issues, many of which were controversial, that needed to be resolved. For example, the House and Senate versions offered differing proposals on covering dual eligibles.

Much of the rising costs in Medicaid programs can be attributed to prescription drug spending by dual eligibles. Though not a mandatory part of Medicaid programs, prescription drug coverage is voluntarily included by all states in their Medicaid benefit packages.

Medical Malpractice Reform: Access and Cost Issues

In 2003, the issue of medical malpractice reform matched the Medicare prescription drug debate for its divisiveness and acrimony. From President Bush to state legislatures to the American Medical Association, every level of government and health care interest group seemed to have something to say about whether the malpractice insurance system needs to be reformed and how.

In 2000, malpractice insurance premium costs in some states began to skyrocket after more than a decade of relatively slow growth. In a representative survey of 700 group practices conducted by the Medical Group Management Association (MGMA), physicians reported an average premium increase of 53 percent between 2002 and 2003. According to the Insurance Information Institute, median malpractice awards jumped 43 percent between 1999 and 2001, from $700,000 to $1 million.

The reasons cited for soaring awards and premiums are as varied as there are players in the game. Physicians point to rising jury awards and trial lawyers who encourage suits against medical professionals and their employers. Consumer advocates and trial lawyers blame poor clinical quality and insurance companies' bad financial investments, noting that premium increases over the past 30 years have not kept pace with medical inflation.

In a July 2003 report, the General Accounting Office (GAO) found that multiple factors led to rising premiums, but that insurers' investment losses and rising reinsurance rates appear to be the primary long-term drivers. (To access the report visit www.gao.gov/new.items/d03702.pdf.) The seven-state report did not recommend congressional action but did suggest that the National Association of Insurance Commissioners and state insurance regulators collect longitudinal data on malpractice claims.

Anecdotal reports from physicians in states with rapidly rising premiums are varied. Some physicians are moving their practice to states with less costly premiums, while others are refusing to perform certain high-risk procedures or practicing "defensive medicine" (i.e., ordering more tests or referring patients to specialists or the emergency room).

Responding to the MGMA survey, more than a quarter of physicians indicated that they might retire, move, or restrict their services over the next three years. Almost 15 percent said they would entirely eliminate the provision of services to high-risk patients. The American Medical Association—which calls medical liability reform its number one legislative priority in Washington—considers 19 states to be "in crisis."

The Center for Studying Health System Change looked at the issue in their 12 nationally representative locations (www.hschange.org/CONTENT/605/). They found that, although varied, provider reactions had resulted in limitations on continuity of care and patient choices across-the-board. These included doctors in some locations no longer delivering babies in order to lower their premiums, and instead referring patients to safety-net facilities. The report notes that this may not only drive up health care costs but could contribute to overcrowding at these facilities. The study did not find that specialists were retiring or relocating due to rising premiums.

"The impact of rising premiums on access to care depends on how you define access," says Robert Berenson, M.D., lead author of the Center study and a senior fellow at the Urban Institute. "Does it mean you can't get the care you need, or does it mean you have to change caregivers?"

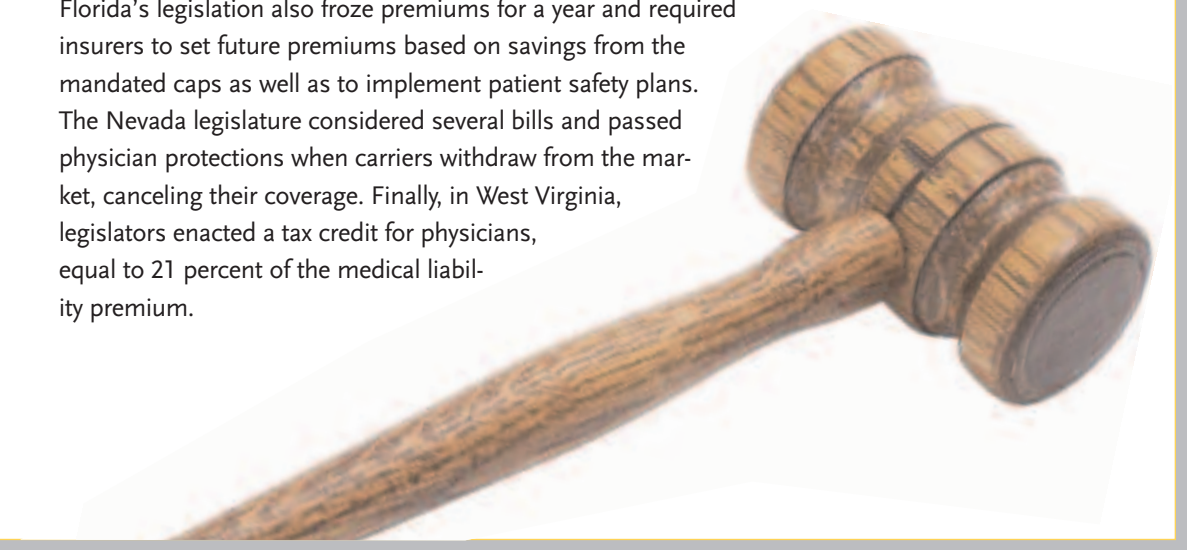
In the August 2003 GAO report, "Implications of Rising Premiums on Access to Health Care" (www.gao.gov/new.items/d03836.pdf), the agency studied nine states—five with high premiums and four without. Like the Center for Studying Health System Change, the GAO found evidence that high premiums cause defensive medical practice and other responses that affect access to care, but GAO concluded that these responses were not widespread. The report also addressed the issue of damage caps, noting that the growth in malpractice premiums and claims payments has been slower in states that enacted tort reform laws with caps on non-economic damages.

Both federal and state appeals for action on this issue have been vigorous. In January 2003, President Bush called for Congress to legislate, among other litigation reforms, a $250,000 cap on claims for non-economic damages. "The medical liability crisis is driving good doctors out of medicine, and leaving patients in many communities without access to both basic and specialty medical services," said the President in a July speech. In the 118th Congress, the House (H.R. 5) and Senate (S. 11) introduced similar legislation that included many of the President's reforms. The House passed the measure, the Senate did not.

According to the National Conference of State Legislatures, 34 states tackled the issue of medical malpractice reform in 2003, with 11 enacting tort reform measures. These include caps on non-economic or punitive damages (or both), court venue reform, establishment of compensation funds, and tax credits for physicians to offset rising premium costs.

In Texas, voters approved Proposition 12, a constitutional amendment that caps malpractice awards at $250,000 and also gives lawmakers sweeping authority to limit similar damages in other lawsuits, provided that three-fifths of House and Senate members agree. After three special sessions, Florida legislated a $500,000 cap on non-economic damages in suits against individual physicians. The cap rises as a larger number of doctors or facilities is involved.

Florida's legislation also froze premiums for a year and required insurers to set future premiums based on savings from the mandated caps as well as to implement patient safety plans. The Nevada legislature considered several bills and passed physician protections when carriers withdraw from the market, canceling their coverage. Finally, in West Virginia, legislators enacted a tax credit for physicians, equal to 21 percent of the medical liability premium.



On December 8, President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Photograph courtesy of the White House Office of Public Affairs.)

The Senate's Prescription Drug and Medicare Improvement Act of 2003 (SR. 1) proposed that low-income seniors remain in their current Medicaid benefit package. The House's Medicare Prescription Drug and Modernization Act of 2003 (HR. 1) would institute a prescription drug benefit for some dual-eligible individuals based on income, with the federal government gradually taking on the drug costs over the course of 15 years. A letter sent to Congress from the governors of all 50 states demonstrated unanimous and open support for the House provision on financing dual eligibles, while the Bush administration supported the Senate's version.

There were many other components of the Medicare reform legislation that concerned state officials. After having shouldered much of the burden for providing drug coverage to seniors for years, states wanted to be sure that they would be given adequate fiscal relief, and that the new provisions would not add to their existing financial or administrative strain.

For example, many state officials feared that the bill would lead to the "woodwork effect"—an increase in state costs due to an immediate increase in seniors enrolling in QMB/SLMB programs as a result of the new drug benefit.

With so many complicated and politically challenging issues to resolve, it was with great surprise that a compromise was eventually reached. In late November, Congress finally passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MPDIMA). The historic passage of this bill, legislating the first major improvement to the Medicare program since the program was enacted in 1965, is expected to cost $400 billion over 10 years.

In light of the upcoming 2004 elections, passage of MPDIMA was a tremendous political achievement for Bush and the Republican party. President Bush signed the bill on December 8, 2003, stating, "With this law, we're giving older Americans better choices and more control over their health care, so they can receive the modern medical care they deserve."

MPDIMA will provide:

- A prescription drug benefit for beneficiaries effective in 2006;
- Subsidies for employers that continue to provide prescription drug coverage to retirees after the drug benefit takes effect;
- More federal money to rural Medicare providers;
- An allowance for the establishment of tax-preferred health savings accounts for individuals; and
- A pilot program in six metropolitan areas in which traditional, fee-for-service Medicare would compete with private health plans.

Although everyone agreed that Medicare reform was long overdue, some experts had reservations about the plan that passed. "Many beneficiaries with very modest incomes will receive limited help from this bill," says Karen Davis, president of The Commonwealth Fund. Although Davis says the legislation is a step in the right direction, she also believes it is unnecessarily limited and complex. "Congress's work is unfinished," she says. "Efforts to provide a better option for Medicare beneficiaries to be a continued priority."

The Democratic presidential candidates came out strongly against the bill, largely because they felt that it caters more to special interests than to low-income seniors, and prohibits the government from negotiating lower drug prices on behalf of beneficiaries. The plan was called everything from a Trojan horse to a turkey stuffed with goodies for the pharmaceutical industry to a poison pill for seniors.

Supporters of the bill countered that seniors will be better off because private health plans will compete for their business by providing better coverage at affordable prices. Thus, private-market competition—and not government price setting—will help control Medicare costs. They contend that private-sector competition will result in more innovation and flexibility in coverage than was previously possible.

The support of AARP, a national seniors organization with 35 million members, was critical to the passage of the legislation. "AARP supported this legislation for one reason and one reason only: It will provide important prescription drug coverage and financial relief for millions of current and future Medicare beneficiaries," said William Novelli, CEO of the organization, in a December 1 statement.

Until the legislation is codified into regulation, it is too early to assess the full impact of the new program. Experts are still trying to understand the 700 pages outlining changes and new options available to beneficiaries.

Initial responses from states indicate that they are overwhelmed by the new legislation and uncertain of the full impact it will have on them. The federal government will assume 25 percent of the cost of providing prescription drug coverage for dual eligibles, phased-in over a 10-year period.

States are particularly concerned with the "clawback" provision included in the massive legislation, which requires states to return a large portion of their savings to the federal government when the program is implemented in 2006. (See Figure 6.) "The overall impact is unclear," says Utah Medicaid Director Michael Deily. "With clawback, will state Medicaid programs be saving dollars or actually spending more? Frankly, we may not know a whole lot more until we actually get into it."

According to the Congressional Budget Office (CBO) estimates, between 2004 and 2013, states will incur an estimated net savings of $17.2 billion, while spending nearly $115 billion on prescription drugs for dual eligibles. In addition to the fiscal impact of the clawback provision, states will face reduced savings as a result of increased administrative loads. Likewise, the imminent surge of baby boom retirees will also be a significant financial burden for state Medicaid programs.

Other Federal Health Care Proposals

Association Health Plans

The past year also saw the Bush administration put forward a number of proposals focused on incremental steps to increase health coverage. The Small Business Health Fairness Act (HR. 660)—which would permit small businesses to pool their efforts to purchase coverage at lower cost through federally certified association plans—was introduced early in the 108th Congress and passed swiftly. Association Health Plans (AHPs) are group health plans whose sponsors include the trade industry, professional groups, chambers of commerce, and similar business associations.

However, the Senate version of this legislation (S. 545) did not have the same momentum as its House version, with only eight senators publicly supporting it as of early October 2003.

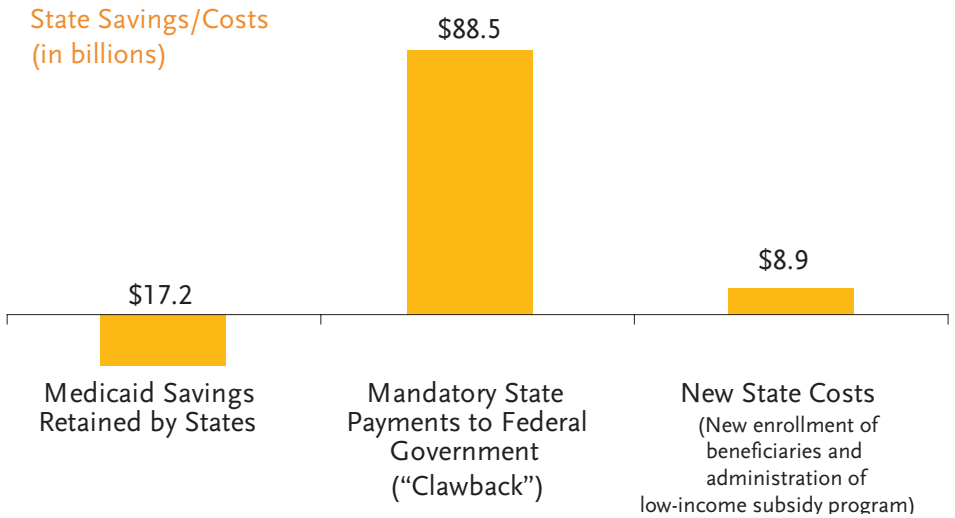
A bipartisan group introduced the legislation to address the issue of uninsurance for small business employees whose employers cannot afford to offer health benefits to their workers. The impetus behind the legislation was for small businesses to develop bargaining power through the AHPs and improve accessibility and affordability of health care coverage.

This proposal spurred animated debate. Criticisms focused especially on the provision to extend ERISA exemptions to AHPs—which would mean these entities would not be subject to local regulation. Opponents charged that federal certification of AHPs would erode consumer protections, allowing exclusion of high-risk beneficiaries, inordinately high premiums, and exclusions or downgrading of coverage, counter to the states' traditional consumer protection role.

"Proponents always say that AHPs are prohibited from discriminating between healthy and less healthy people under the proposed federal law," says Enrique Martinez-Vidal, deputy director for perform-

Figure 6: Estimated Impact of the Medicare Law on State Medicaid Spending

(FY 2004 – 2013)



Note: Estimates do not include the effects of Medicaid provisions in Title X of H.R. 1.
SOURCE: KCMU analysis of Congressional Budget Office estimates, 2003.

ance and benefits at the Maryland Health Care Commission. "In fact, because AHPs are exempt from most state oversight, including mandated benefits, they can offer more limited benefit plans that only the healthy are likely to choose, thereby leaving the less healthy in a shrinking pool with increasing premiums."

However, the CBO estimated that AHPs would result in higher premiums for 80 percent of small businesses and their workers—which, in turn, could contribute to an increase in the number of uninsured.

The Trade Act

In another effort to increase coverage in the private insurance market, the Bush administration moved forward on implementation of the new tax credit created by the Trade Act of 2002. The tax credit enables some U.S. workers who receive guaranteed pensions or who have lost their jobs due to foreign competition to purchase private health insurance coverage.

The health coverage tax credits pay 65 percent of health insurance premiums, and are fully refundable and claimable as advance payments during the year or as a lump sum at the end of the year. Ruben King-Shaw, Jr., senior advisor to Secretary Thompson for health insurance initiatives, led this work in conjunction with several federal agencies, including HHS, the Internal Revenue Service, the Department of Treasury, and the Department of Labor.

Twenty-six states have taken advantage of the new tax-credit provisions since they were implemented, with the first advance payment distributed on August 1, 2003. As federal agencies work with states to reach out to eligible populations, they are learning from the process and evaluating the feasibility of using tax credits as a means of expanding coverage to other uninsured.

On the Horizon

Also proposing refundable tax credits, Senator Grassley (R-Iowa) with co-sponsors Senator Max Baucus (D-Mont.), Senator John Breaux (D-La.), and Senator Gordon Smith (R-Ore.) introduced The Health Care Tax Credit Expansion Act of 2003 (S. 1693) in early October, shortly after the Census Bureau released the disappointing news that the number of U.S. uninsured had increased.

The plan would provide a tax credit equal to 65 percent of monthly premium charges for unemployed workers on unemployment insurance, building on the infrastructure of the Trade Act tax credit program.

PRIVATE INSURANCE MARKET TRENDS AND STATE REFORMS

While states were confronted with significant fiscal and programmatic challenges in 2003, they also faced sizable challenges in stabilizing their private health insurance markets. Insurance premiums continued to climb rapidly, and many employers were forced to make difficult choices about whether to continue to offer health insurance benefits or make benefit reductions.

"We've reached a point, in my judgment, where the bubble has burst," says Eric Serna, superintendent of the New Mexico Department of Insurance. Affordable coverage in the private market has, in general, become much more difficult to obtain over the past several years.

"An increasing share of our workforce is finding it harder and harder to purchase comprehensive insurance as we have come to know it," noted Len Nichols, vice president for the Center for Studying Health System Change, in his testimony before a U.S. Senate subcommittee.

For their part, states have sought to accomplish a number of different and sometimes conflicting objectives in the effort to shore up their private insurance markets. Primarily, they have sought to:

- Ensure the solvency of plans serving the small-group and non-group markets;
- Maintain, or in some cases increase, the number of residents covered through private insurance;
- Improve the affordability of private coverage products;
- Maintain the comprehensiveness of covered benefits or help design reasonably adequate "streamlined" packages; and
- Increase, or maintain, the number of active carriers in the state to foster a more competitive market.

Increasingly Unaffordable Coverage in Private Markets

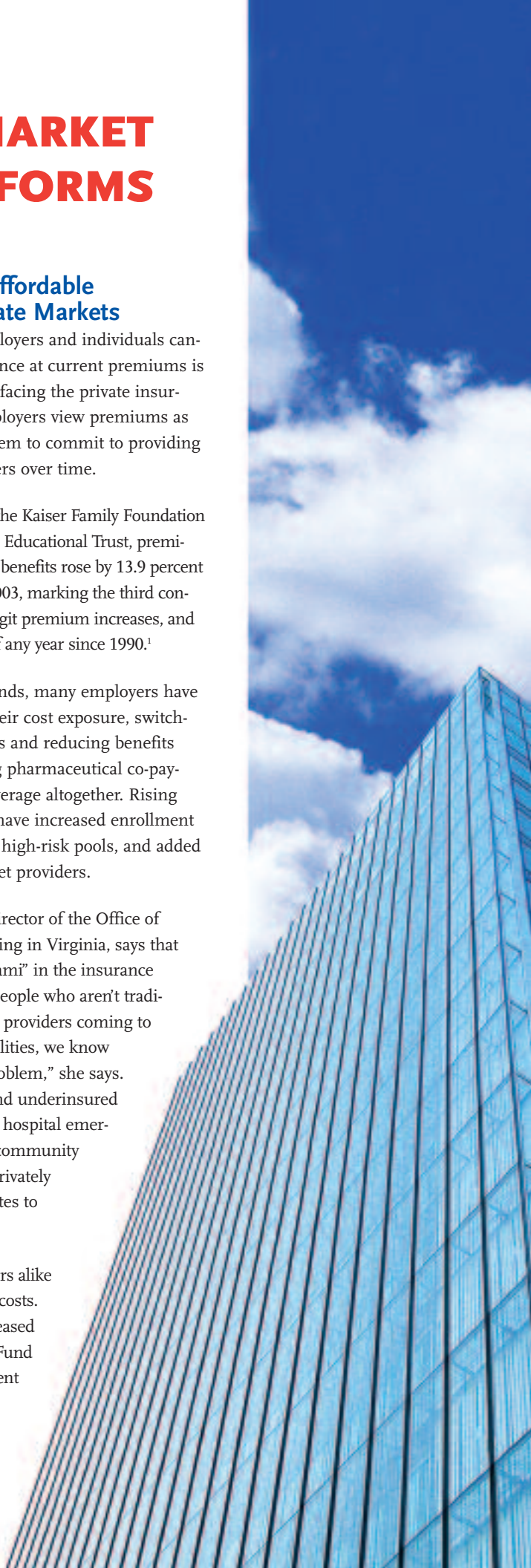
The fact that many employers and individuals cannot afford health insurance at current premiums is central to the challenge facing the private insurance market. Many employers view premiums as too unpredictable for them to commit to providing coverage for their workers over time.

According to a report by the Kaiser Family Foundation and Health Research and Educational Trust, premiums for job-based health benefits rose by 13.9 percent in the United States in 2003, marking the third consecutive year of double-digit premium increases, and a higher rate of growth of any year since 1990.[1]

In response to these trends, many employers have taken steps to reduce their cost exposure, switching to lower cost carriers and reducing benefits (especially by increasing pharmaceutical co-payments), or dropping coverage altogether. Rising numbers of uninsured have increased enrollment in public programs and high-risk pools, and added to the strain on safety-net providers.

Renee Cabral-Daniels, director of the Office of Health Policy and Planning in Virginia, says that states are facing a "tsunami" in the insurance market. "When we see people who aren't traditional users of safety-net providers coming to be seen in safety-net facilities, we know there's an underlying problem," she says. With more uninsured and underinsured patients being treated in hospital emergency rooms and other community clinics, cost-shifting to privately insured groups contributes to rising premiums.

Large and small employers alike confront high insurance costs. According to a report released by The Commonwealth Fund in October 2003, 32 percent of workers who lacked health coverage in 2001 were employed by large



With many states facing fiscal crises and the need to limit their own financial exposure, they generally gave less consideration to insurance subsidies in 2003 than in previous years.

firms with 500 or more employees.[2] Other research showed that 39 percent of small to mid-size employers (3 – 199 employees) did not offer coverage to their workers in 2002.[3]

Fostering Competition Among Carriers

Many business owners, as well as insurance brokers and state legislators, contend that the small number of insurers competing in the marketplace is largely to blame for the rising cost of health insurance. "The perception is that costs are going up because there is not enough competition," says Enrique Martinez-Vidal, deputy director for performance and benefits at the Maryland Health Care Commission. He notes that the desire to bring more carriers—and more competition—into the commercial marketplace often conflicts with existing patient protections, such as benefit mandates and guaranteed issue requirements.

Focus groups of small employers that were conducted as part of the State Planning Grant (SPG) program for the Health Resources and Services Administration (HRSA) reflect concern about market consolidation. For example, the Vermont SPG team reported that "many employers indicated that increased insurer competition would be the most important catalyst to reducing premiums."[4]

In an SCI report released in fall 2003, Deborah Chollet, Ph.D., and colleagues state that, "the rising cost of health care and health insurance underlies an ongoing restructuring of health insurance markets in many states, as insurers seek to gain premium volume and market share." The authors note that the changes have led to "the dominance of fewer, larger insurers."[5] (Figure 7 illustrates the trend toward consolidation.)

Whether easing state regulatory requirements and attracting more carriers would actually lead to lower premiums is an open debate. Smaller carriers—the type that might enter a marketplace if regulations were eased—may be able to compete only by attracting healthier enrollees. Thus, a move to relax state laws could lead to market segmentation. This type of competition may offer some employers cost relief, but could destabilize the market for employers with older or sicker workers and dependents.

Recent studies suggest that eliminating mandated benefits might lower premiums, but probably not enough to attract new employers to offer coverage, or to prevent others from dropping it.[6] Also, this strategy may contribute to underinsurance.

New Directions for Employers and Plans

Many employers have responded to rising insurance premiums by reducing their premium contributions (especially for dependent coverage) or raising employee cost-sharing. Some have moved to high-deductible policies, which lower premiums but increase enrollee out-of-pocket costs. Benefit reductions such as these have prompted a backlash from labor groups. In California, for example, labor protests over reduced health benefits shut down the nation's third-largest public transportation system in late 2003.

Having abandoned strongly managed care to control health care costs, many insurers refocused on developing "streamlined" insurance products and "consumer-directed" products, and on eliminating state-mandated benefits for services such as chiropractic care and in-vitro fertilization. A number of states have been investigating how to loosen insurance market rules to allow plans to craft an affordable insurance package for small employers.

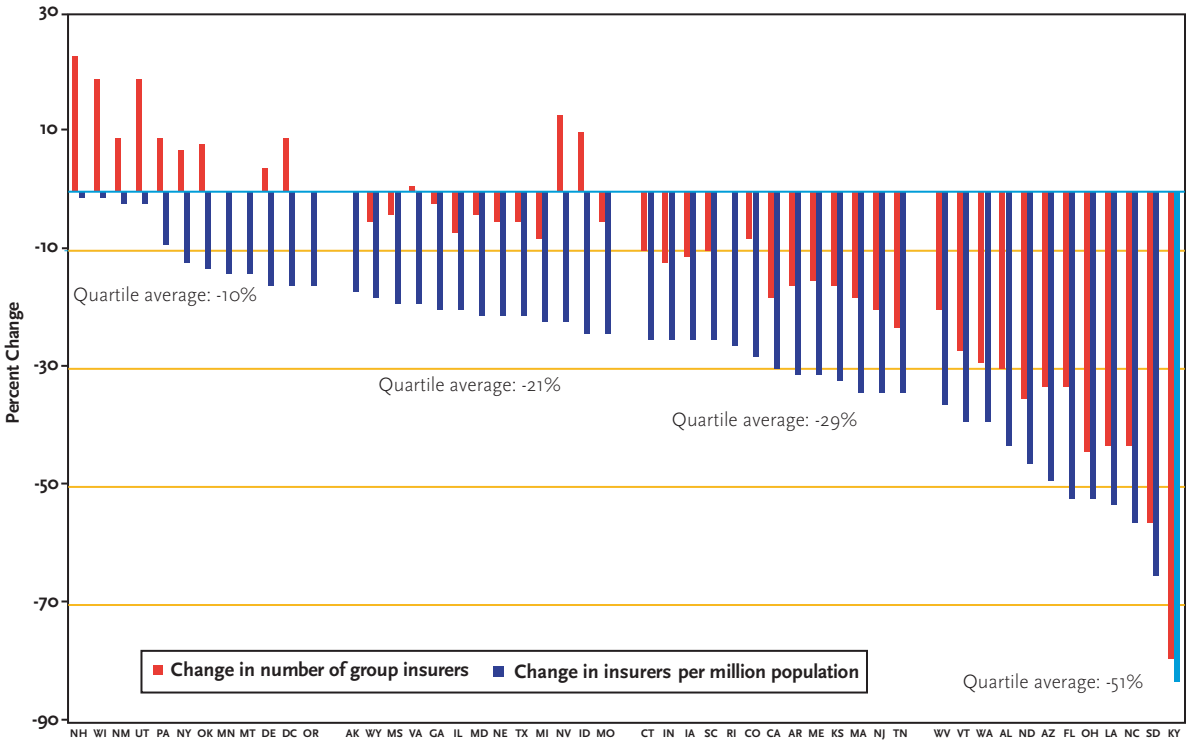
State Responses

With many states facing fiscal crises and the need to limit their own financial exposure, they generally gave less attention to consideration of insurance subsidies in 2003. Instead, they focused on narrowing benefit packages. According to Sonia Chambers, co-project leader of the West Virginia SPG and chair of the state Health Care Authority, the question has been "how to make meaningful insurance coverage available for the people we're trying to reach without committing new state dollars."

For many employees of small firms in West Virginia, "there's no way they can afford anything more than $100 per month, if that," says Chambers. "However, meaningful insurance can price out at $300 per month." This has created a significant challenge for West Virginia and other states that are seeking to reduce uninsurance rates.

In 2003, Florida's Lieutenant Governor Toni Jennings (R) said that the state's business climate was being threatened by the rising cost of providing health insurance benefits to employees. The Jeb Bush (R) administration in Florida has put together a Governor's Task Force on Access to Affordable Health Insurance. The task force is charged with producing policy recommendations to be considered in the state's 2004 legislative session. Its efforts parallel an initiative mounted by the state legislature to consider ways to preserve and expand private health insurance. Both bodies

Figure 7: Change in Number of Group Insurers and Insurers per Million Population: Group Market, 2001



Source: AcademyHealth, Health Insurer Database. 1997 data are unavailable for Hawaii.
Note: Absence of bar indicates value equal to zero.

may recommend provisions to encourage alternative benefit products.

In New York, the state's streamlined benefit product for the small-group and individual markets, called "Healthy New York," has been in operation for three years. This product offers small employers and individuals a lower cost insurance option that includes a slightly trimmed-down benefit package, significant enrollee cost-sharing, and more recently, an optional pharmaceutical benefit.

While commercial plans offer the Healthy New York product, the state provides financial support through a risk-sharing arrangement, assuming partial financial risk for enrollees with high medical expenses during the year. Beginning in 2003, the state assumed financial responsibility for 90 percent of the claims costs for individuals with expenses totaling between $5,000 and $75,000 annually (compared to a risk corridor of $30,000 to $100,000 in previous years).

The new corridor reflects the fact that program costs and enrollment were lower than expected in the initial years of operation. New York expects that the lower risk-sharing corridor would reduce premiums and increase enrollment. More than 40,000 people are now enrolled in the program. The Department of Insurance has launched an advertising campaign featuring Governor Pataki (R) to further boost enrollment.

The State of State High-Risk Pools

To shore up their insurance markets, 31 states have established high-risk pools that provide access to insurance for individuals who have been denied coverage in the private market. "We're seeing more interest across the country in trying to tackle the access problem in some fashion, and risk pools are one of the options out there," says Bruce Abbe, vice president of public affairs for Communicating for Agriculture, a rural advocacy group. As of June 2003, 172,000 people were enrolled in high-risk pools nationwide, a 13 percent increase over 2002.

The Trade Act of 2002 authorized the federal government to provide $20 million in seed money for states to establish risk pools in 2003, as well as $80 million over two years to shore up existing pools—providing that they met certain requirements, such as adhering to specific rate bands and being open to new enrollees. According to Abbe, the start-up money spurred a lot of interest among states.

In 2003, both South Dakota and Maryland established new risk pools, and a number of others considered doing so. Some states are now hoping that federal funding will carry forward into 2004, giving them another opportunity to take advantage of it. Twenty states applied for federal financial assistance for their existing pools through Trade Adjustment Assistance, says Abbe.

To manage high-risk pool costs, states are increasingly interested in care- and disease-management programs. This approach focuses on managing the chronic illnesses of enrolled members to avoid medical complications and higher service utilization. In 2003, five states—Arkansas, Colorado, Kansas, Oklahoma, and Washington—worked together to develop a data-sharing system to support care management.

According to Barbara Brett, executive director of Colorado's high-risk pool, each state contributed two years of medical and pharmacy claims data for use with predictive modeling software to compare the health status of participants among the states.

The goal of this study is to be able to predict which participants are likely to be high utilizers. (In the future, enrollees may also complete a brief questionnaire as part of this effort.) With this information, the states are able to target enrollees who are most likely to benefit from disease management. Early results indicate that the program has been successful in holding down costs for these enrollees.

Endnotes

1 The Kaiser Family Foundation and Health Research and Educational Trust (HRET), Employer Health Benefits 2003 Annual Survey, September 2003, p. 18. (See www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=20672.)

2 Glied, S. et al. "The Growing Share of Uninsured Workers Employed by Large Firms," a report published by the Commonwealth Fund, October 2003. (See http://cmwf.org/programs/insurance/glied%5Flargefirms%5Fbn%5F672.asp.)

3 The Kaiser/HRET 2002 National Survey of Employers: What Are Its Implications for Health Insurance? (See www.ehcca.com/presentations/healthpolicyaudio20020924/gabel.pdf).

4 www.statecoverage.net/statereports/vt1.pdf (Views on Health Insurance and the Uninsured in Vermont: A Qualitative Study).

5 Chollet, D. et al. "Mapping State Health Insurance Markets, 2001: Structure and Change," a report published by the State Coverage Initiatives program, AcademyHealth, September 2003, p. 9. Also available at www.statecoverage.net/techmanuals.htm.

6 For a discussion, see "Health Insurance Regulation in Texas: The Impact of Mandated Health Benefits," www.statecoverage.net/statereports/tx2.pdf.

STATE PLANNING AND DEMONSTATION EFFORTS

As the states continued to grapple with economic recessions and budget shortfalls in 2003, they received some much-needed help in the form of grants provided through the State Coverage Initiatives (SCI) and the Health Resources and Services Administration's (HRSA) State Planning Grant (SPG) programs. The activities that the states engaged in under their grants indicate how they are managing to address the uninsured in light of their dire fiscal situations: They are placing an increased emphasis on public-private partnerships, using state-specific data to support policy decisions, and interacting with the public to gain broader input into the policy process.

Round II SCI Demonstration Grants

To date, the SCI program has awarded two rounds of demonstration grants to seven states: four received awards in October 2001 and three in January 2003. These funds are intended to support states that have selected a coverage expansion mechanism and seek assistance in designing and implementing it. The grants range from $1 million to $1.5 million each, and the demonstration projects run for up to three years. (For more information on SCI's grant programs or its current grantees, visit www.statecoverage.net/grants.htm.)

Virginia Zeros in on Priority Populations

SCI awarded $1.1 million to the Commonwealth of Virginia to focus on three priority populations: pregnant women and their children, employees of small businesses, and low-income parents and single adults. The grant team in the state's Office of the Secretary of Health and Human Services proposed addressing the groups in that order and has spent the first year focusing on pregnant women and children. Earlier in 2003, Virginia submitted a concept paper to the Centers for Medicare and Medicaid Services (CMS) outlining their ideas for two waivers: a Health Insurance Flexibility and Accountability (HIFA) waiver for the expansion to pregnant women and children, and an 1115 waiver for coverage for small employers.

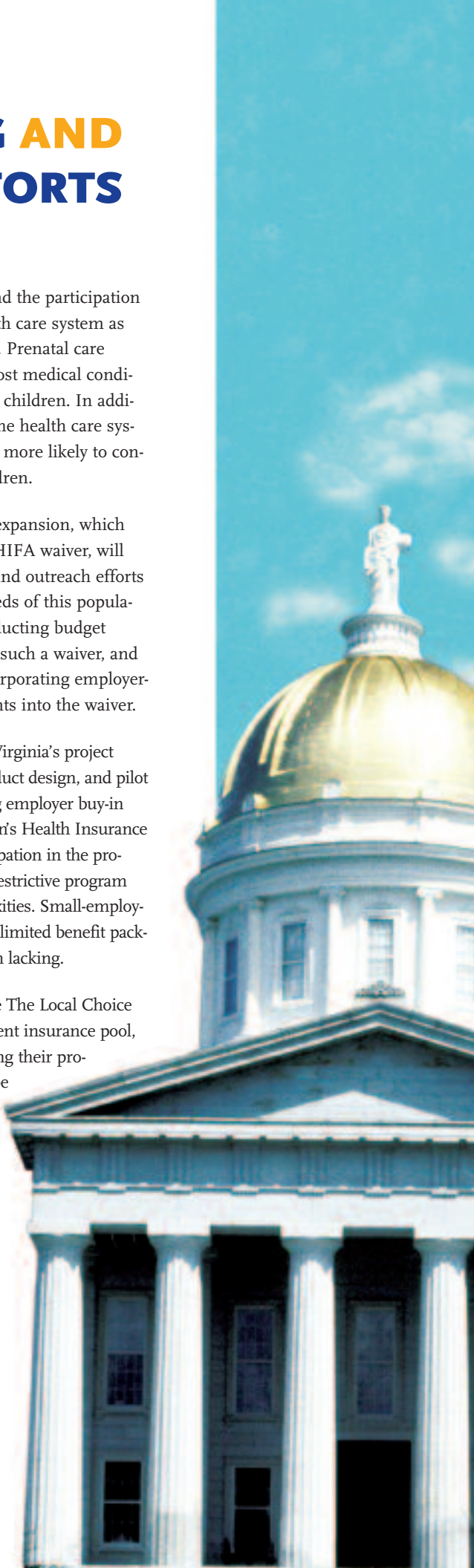
The state views prenatal care and the participation of pregnant women in the health care system as important preventive measures. Prenatal care lessens the likelihood of high-cost medical conditions for both women and their children. In addition, mothers who are kept in the health care system during their pregnancy are more likely to continue to seek care for their children.

Virginia officials say that their expansion, which they plan to pursue through a HIFA waiver, will include benefits, cost sharing, and outreach efforts tailored to meet the specific needs of this population. The state is currently conducting budget analyses to estimate the cost of such a waiver, and of including provisions for incorporating employer-sponsored insurance components into the waiver.

In the second year of the grant, Virginia's project team will focus on research, product design, and pilot programs to improve the existing employer buy-in program under the State Children's Health Insurance Program (SCHIP). So far, participation in the program has been minimal due to restrictive program rules and administrative complexities. Small-employer interest in the state-mandated limited benefit package offered to them has also been lacking.

The grant team will also evaluate The Local Choice (TLC) program, a local government insurance pool, as a potential model for modifying their program. If this model is found to be viable, the state will submit an 1115 wavier to create it.

The demonstration team has recently joined efforts with the team working on Virginia's HRSA grant, which the state received in September 2003. "Between the State Planning Grant and the SCI grant, we have the capability to look at a wide range of options," says acting SCI grant director Stephen Horan. "We are excited to get started."



West Virginia's grant team believes that community insurance agents and brokers will be key to their demonstration program's success. The team is working with them to ensure that they have the necessary training and support.

West Virginia Works with Small Businesses

West Virginia was awarded $1.36 million to design a coverage expansion to small businesses. The West Virginia Public Employee Insurance Administration (PEIA), which is the agency administering the grant, operates an insurance pool for local government employees that covers about 8,000 lives. The state plans to enroll small businesses in this pool—a move that could double enrollment. By building on PEIA's existing administrative structures and market rate leverage, the state hopes to provide a more affordable and comprehensive benefit option to small businesses.

However, West Virginia officials are aware that those already in the pool may resist the proposal due to concerns that new enrollees, if in poorer health, could drive premium increases for the entire group. For this reason, the grant team has spent much of its first year holding community meetings to solicit input on the project. These events have ranged from meetings of current and future PEIA employees to stakeholder town halls and focus groups to discuss benefit package design.

PEIA Director Tom Susman and Sally Richardson, executive director of the West Virginia University Institute for Health Policy Research (PEIA's partner on the grant), spent the summer and fall of 2003 traveling the state to conduct these meetings. The first meeting of the Policy Advisory Council (PAC), which includes a number of stakeholders including Mountain State Blue Cross/Blue Shield, was held at the end of June. They have met several times since then.

The grant team has realized from its meetings with the public and the PAC that it may need to make compromises to obtain Mountain State's support. These may include adopting crowd-out measures and geographic limitations, or focusing on fewer employers (perhaps only groups of 2 to 10) than the state had initially anticipated. West Virginia officials hope to use the input they received at their public meetings and the PAC to resolve these contentious issues.

West Virginia will pay special attention to both its marketing strategy and the design of the administrative structure for billing and collections. The grant team believes that community insurance agents and brokers will be key to the demonstration's success. They are working with them to ensure that they have the necessary training and support to handle the PEIA product.

PEIA is also working to ensure that small employers, many of whom lack the human resources capabilities of large companies, have a system that meets their needs and is easy and painless to maneuver. If the model proves to be viable, the state has proposed expanding the administrative structure. The state may also provide sliding-scale subsidies to the low-income employees eligible for the program or provide incentives for employers to participate in the program.

Hawaii Aims for Universal Coverage

SCI awarded the Hawaii Department of Health $1.35 million to use a combination of strategies to achieve universal health insurance coverage in the state. These strategies include an Uncovered Worker Access Pool, full enrollment of all eligibles, a children's coverage expansion, expansion and enhancement of the safety net, and exploring options for Compact of Free Association States.[1] They are also working toward gaining a better public understanding of Hawaii's Prepaid Health Care Act.[2] The SCI grant is supporting the first three of these strategies.

In the first year of the grant, the project team conducted a general public survey to gauge the viewpoints, attitudes, and behaviors of both insured and uninsured Hawaiians, including specific segments of the workforce—self employed, part-time workers, and others exempt from coverage under Hawaii's Prepaid Health Care Act. The team held a series of focus groups with employers to understand better their viewpoints on health coverage provisions to employees and their attitudes about uninsurance in Hawaii. Finally, the team launched a statewide employer survey.

Community-relations activities to generate public involvement have included a comprehensive statewide media relations campaign, a quarterly newsletter to educate policymakers and the public, and an informational Web site. In the future, the team will expand work groups to include key advocacy groups and other organizations and try to engage them in endorsing the project's efforts. A speakers program and statewide community meetings will also play a role in the future.

Government relations activities will include one-on-one meetings, presentations, and overall education of key legislators and other policymakers who could help implement the strategies.

The Hawaii Department of Health has also received a HRSA SPG grant, which funds a university team of researchers to perform original research and to analyze existing data from a wide variety of surveys. So far, they have developed a sociodemographic profile of the uninsured. By conducting more than 200 interviews with uninsured individuals and their providers, they have also captured common themes about what it is like to be uninsured in Hawaii. Economic modeling will continue into 2004 to project the impact of various policy scenarios to expand coverage.

Round I Demonstrations Continue to Make Progress

The first states to be awarded SCI demonstration grants have not only built on their year-one activities, but have adapted their plans in light of their worsening budget situations and changed political environments.

Arkansas Pursues Public-Private Partnerships

The Arkansas grant team participated in the Cover the Uninsured Week campaign activities in Little Rock in an effort to educate the state about the uninsured. (For more information on The Robert Wood Johnson Foundation's Cover the Uninsured Week, please see box on p. 32.) The greatest accomplishment of that week was the public-private interface that occurred, says Kevin Ryan, project director at the Arkansas Center for Health Improvement (ACHI). "I am happy that our work under both our SCI and HRSA grants allowed us to play an integral role in helping that to occur," he says.

Based at ACHI, the grant's second-year activities also attempted to "push the envelope to make the most difference," according to Principal Investigator Joe Thompson, M.D., referring to the HIFA waiver that the team helped the Arkansas Department of Human Services to prepare. In January 2003, Governor Mike Huckabee (R) submitted the waiver to Tommy Thompson, Secretary of the U.S. Department of Health and Human Services. Among other things, the waiver proposes that participating employer fees (premium contributions) paid to the state qualify for federal match under the state's plan. Arkansas was still awaiting approval from CMS at the time that this publication went to press.

Oregon Continues its Tradition of Bold Reform

The Oregon's Office of Health Policy and Research (OHPR) provides policy oversight for the state's demonstration grant. "We're where the rocky road has left us," says Bruce Goldberg, administrator of the OHPR. "But that is a pretty amazing place considering the circumstances." The state's legislature cut state spending by 5 percent, but further cuts were required due to continually growing unemployment and revenue shortfalls.

Oregon, however, has maintained coverage for the non-categorical Medicaid-eligible population. The legislature originally cut chemical dependency and mental health treatment for non-categorical individuals, but subsequently restored coverage for those services. "That was an affirmation by the legislature of the importance of the Oregon Health Plan and low-income coverage," says Goldberg. The grant team, however, has continued to look for cost-saving opportunities. In September, the office submitted an 1115 waiver amendment to CMS requesting to restructure portions of its current 1115 waiver, the Oregon Health Plan (OHP).

In its amendment, the state proposes to redefine the benefit package for the OHP Standard Population, which consists of single adults and childless couples with incomes up to 100 percent of the federal poverty level (FPL). The state would like the flexibility to limit dental and inpatient hospital benefits, and to discontinue some optional services.

In February, the state was forced to terminate its Medically Needy program due to a lack of funds. The state has since restored the program for people with HIV/AIDS and recipients of donor organs. The amendment also proposes some expansions, including the creation of Medical Expansion for Disabled and Seniors (MEDS). This expansion would provide prescription drugs to low-income, elderly, and disabled individuals, restoring some coverage for many of those affected by the end of the Medically Needy program.

The amendment also includes an expansion of eligibility for SCHIP and Oregon's premium-assistance program (The Family Health Insurance Assistance Program) to children and individuals up to 200 percent FPL, an increase from the current level of 185 percent FPL.

The first states to be awarded SCI demonstration grants have not only built on their year-one activities, but have adapted their plans in light of their worsening budget situations and changed political environments.

RWJF Raises Nation's Awareness of Uninsured

In September 2003, the U.S. Census Bureau released new figures indicating that the number of Americans lacking health insurance climbed by 5.7 percent in 2002, to 43.6 million, the largest single increase in a decade. The story made headlines across the country, including on the front pages of *The Washington Post*, *The New York Times*, and *The Wall Street Journal*. For The Robert Wood Johnson Foundation, however, the plight of the uninsured is more than the news of the day; educating the public about this problem is a core mission of the organization.

In March, the Foundation set forth "Cover the Uninsured Week," a campaign to raise awareness about the real-life consequences of being uninsured in America. Through nearly 900 events in communities from coast to coast, organizers planned health fairs, town hall meetings, campus activities, discussions between business and labor leaders, community-wide interfaith prayer breakfasts, and other events to help people learn about the issue. Twenty U.S. senators and 43 members of the House participated in various activities.

"For too long we have allowed the numbers of uninsured Americans to rise by millions without engaging in a serious discussion about how we might help them," says Risa Lavizzo-Mourey, M.D., president and CEO of the Foundation. "The unacceptably high number of uninsured Americans, a majority of them in working families, means that people from every walk of life and point of view can and must work very hard in the coming year to guarantee that all Americans have the health care coverage they need."

Some of the most influential organizations in the country, such as AARP, the American Medical Association, the Federation of American Hospitals, and the United Way, supported Cover the Uninsured Week. Former Presidents Gerald Ford and Jimmy Carter lent their names as honorary co-chairs.

"It is critical that we increase awareness about the plight of the uninsured across the nation," says John J. Sweeney, president of the AFL-CIO, a sponsor of the campaign. "People without health insurance live sicker and die younger than their insured counterparts," he says. "Thus, having health insurance can literally mean life or death for some people."

Sweeney's point is illustrated by the following facts:

- Uninsured women who develop breast cancer are twice as likely to die than insured women with the same diagnosis.
- Uninsured men are nearly twice as likely to be diagnosed at a late stage of colon cancer than insured men.
- Uninsured children who need medical or surgical care are four times more likely to go without care than insured children with the same needs.

Many of the uninsured are working individuals who cannot afford health insurance—through their employer or in the individual market—because of rising health care premiums. The sluggish economy and skyrocketing costs of medical care have made it difficult at best for many small employers (under 50 employees) to continue to offer coverage. While public programs such as Medicaid and the State Children's Health Insurance Program have helped to bridge the gap, especially for children, the programs simply are not enough to combat the economic factors at play.

The campaign has yielded impressive results with regard to public awareness. Seven states held 26 or more events for the week of March 10 – 16. In California, 400 people were enrolled in various local health insurance programs during the St. Anthony's Church Health Fair in San Francisco. In Massachusetts, organizers in Boston hosted a town hall meeting at historic Faneuil Hall, where 300 people came to learn about the problem.

In New York, more than 200 health fairs and events took place throughout the five boroughs of New York City. And in Ohio, approximately 350 people attended the Columbus town hall meeting on March 10, where Senator George Voinovich (R) spoke about the need to address the issue of the uninsured.

According to Stuart Schear, senior communications officer for the Foundation, the campaign generated significant media coverage. More than 378 million media impressions from more than 3,000 television, radio, newspaper, and magazine stories resulted.

Many of the nation's top television scriptwriters, including writers for "ER," "Law and Order: Special Victim's Unit," "Frasier," and "Judging Amy," incorporated the issue of the uninsured into their shows' storylines or produced public service announcements promoting the Foundation's campaign.

"Perhaps more significant than the media buzz," says Schear, "was the awareness achieved among Washington, D.C., opinion leaders[1], 51 percent of whom now rank coverage of the uninsured as the nation's top goal in improving our health care system."

The 2004 campaign has been slated for May 10 – 16. It will begin with a national kick-off event, followed by more than 1,000 events held by community groups from coast to coast. Next year's effort will also feature physicians, nurses, and other health professionals who donate a portion of their time during the week to care for the uninsured.

To learn more about Cover the Uninsured Week, visit www.covertheuninsuredweek.org.

1 Opinion Leaders are defined as registered voters, age 18 – 70, with an education level of some college or higher; "very/somewhat likely" to vote in elections; "very/somewhat closely" follow politics or current events; watch CNN, Fox News Channel, or MSNBC daily; among other factors.

"People relate to stories," says Kinzel. "They relate even better to stories when they can see the people telling them."

Iowa Gets Creative with Supplemental HRSA Funds

Iowa is one of 23 states (plus the Virgin Islands) to receive a total of $4.3 million from the Health Resources and Services Administration (HRSA) in October in order to supplement a previously awarded state planning grant. Many of the states to receive such supplemental funds used the money to conduct additional surveys, updating existing instruments, or perform economic modeling. Iowa, however, is using the funds for a truly unique project.

The "Real to Reel" project will create a documentary about rural health care and access in America. According to Anne Kinzel, Iowa's SPG project director, the project's impetus comes from the origins of the environmental movement and the work of Rachel Carson, whose book *Silent Spring* highlighted the dangers of pesticides. Carson's work was adapted into a documentary, which many people believe helped drive much grass-roots support for environmental causes.

"People relate to stories," says Kinzel. "They relate even better to stories when they can see the people telling them." Iowa's past SPG research documented the relationship between people's fear of losing health insurance and their likelihood of making major life decisions, such as starting a business, taking a new job, retiring before age 65, and timing when to have a child. With the help of a University of Iowa health economist, Iowa will attach a dollar number to the impact of these life decisions, along with the effect of rising health insurance costs on job creation.

"This is the part that makes this study innovative," says researcher J. Ann Selzer. "No one who is talking about economic development is connecting it to access to health insurance." The grant team hopes their research will change the way that people think. The project will require further funding, and Kinzel is pursuing various options. (The federal SPG funds will support the census research for the project.) Iowa Public Television, the statewide public television network, has given preliminary approval to air the documentary in fall 2004, which is the presidential election season. "It should be interesting," says Kinzel.

The last, and most controversial, portion of the team's proposal is their request to modify OHP's prioritized list of health services, which the state uses to determine which services it will cover. The list ranks health care procedures according to the severity of the condition they are intended to address, the efficacy of the testing or treatment under consideration, and public values. Based on their determination, OHP officials assign each service a numerical value; the lower the number associated with a given treatment or service, the more the state considers it to be worth covering with public dollars.

Currently, the state covers all procedures that score 549 or higher on the list. The amendment proposes shifting that "line" to 519, so that the OHP would cover fewer services. None of the eliminated benefits are for life-threatening conditions, however. Some of the services that will fall below the line are those for which there is not adequate evidence showing that they are clinically efficacious. The state hopes that, by focusing on preventive care, it can help people to avoid chronic conditions altogether.

Figure 8: HRSA Round IV State Planning Grant Awards

State	Organization	Award
DC	District of Columbia Department of Health	$990,000
FL	Florida Agency for Health Care Administration	$975,000
*MS	Mississippi Division of Medicaid	$1,245,699
MO	Missouri Department of Health and Senior Services	$938,489
NE	Nebraska Department of Health	$776,522
NM	New Mexico Human Services Department	$905,000
*ND	North Dakota Department of Health	$781,889
OK	Oklahoma Health Care Authority	$874,360
RI	Rhode Island Department of Human Services	$961,156
VA	Virginia Department of Health	$969,729
Total:		**$9,417,844**

** July 2003 awardees*

Rhode Island: Doing the RIte Thing

Like many states, Rhode Island has had to adjust its grant activities due to the nationwide recession. Through its Department of Human Services, Rhode Island is using its funds to monitor and refine RIte Share, which is the state's premium-assistance program. RIte Share's goal is to ensure that low-income working families can maintain or enroll in employer-sponsored coverage. This will help the state to moderate enrollment growth and costs in the state's Medicaid managed care program, RIte Care, while continuing to provide access to affordable health coverage for working families.

During the grant's second year, the team has focused on conducting a formative evaluation of RIte Share's operating policies, procedures, and systems, so that they can determine the best way to increase enrollment. RIte Share is ending 2003 as a success, having exceeded projections by enrolling more than 5,000 members, or 4 percent of the RIte Care population.

In addition, the state used SCI grant funds to quantify the cost savings realized by the RIte Share program. Because Rhode Island shares the costs for RIte Share with participating employers, the state saves an estimated $1 million for every 1,000 people it enrolls in RIte Share instead of RIte Care.

"RIte Share has allowed Rhode Island to maintain its RIte Care program expansion to uninsured families by containing public costs," says Tricia Leddy, administrator for Child and Family Health in the Rhode Island Department of Human Services.

The state was awarded a Round IV HRSA SPG grant that will help them answer many of the additional questions they have about their private insurance market and its impact on public program costs and uninsurance rates. Soon, the state will begin targeting research and policy analysis to develop options to address the affordability of employer-sponsored coverage. Many of the significant lessons that the state has learned while implementing RIte Care and RIte Share will give it a head start as it seeks to find solutions to ensure that coverage is affordable for all the state's residents.

New Mexico Revisits Its Premium-Assistance Model

Due to a shift in New Mexico's political landscape—including the election of a new governor in the fall of 2002—New Mexico is re-evaluating its HIFA waiver to develop a premium-assistance program that combines federal, state, and employer dollars. Governor Bill Richardson (D) is still planning to implement the state's HIFA waiver, which was approved in August 2002. However, "we are

The states have targeted their grant activities to their particular uninsured populations. For example, Virginia, one of the states with the highest rates of employer-sponsored insurance (ESI), will try to fold service-sector employees into its robust ESI base.

trying to incorporate many individuals and groups who felt they were not included in the discussions," says Dan Harris, chief economist in the Medical Assistance Division in the New Mexico Human Services Department. "The benefit package and cost-sharing structure are being reexamined by advocates, legislators, and representatives from all agencies that will be involved in the program's implementation."

The state is currently evaluating the actuarial differences in the prior approved benefit packages and other packages that they are considering. Once these figures are known, they will be presented to stakeholders for further discussion. Limitations on the cost-sharing structure, primarily out-of-pocket payments, are the focus of these negotiations. In addition, "the state would like to make this product relatively consistent with the direction of other changes under the redesign of the Medicaid program," says Carolyn Ingram, New Mexico's Medicaid director.

HRSA SPG Program Continues with a Fourth Round

On October 1, Tommy Thompson, Secretary of the U.S. Department of Health and Human Services, announced that HRSA would award eight additional State Planning Grants, totaling $7.4 million. More than half of the states in the country had already received the one-year, $1 million grants, which are intended to help states to conduct research on their uninsured and develop policy options to maintain or expand coverage.

The new HRSA grants were awarded to the District of Columbia, Florida, Missouri, Nebraska, New Mexico, Oklahoma, Rhode Island, and Virginia. Mississippi and North Dakota also received grants in July totaling $2 million. (See Figure 8, page 35.) The fourth round of grantees includes states that are health reform veterans as well as those that are new to such initiatives.

Just as the states funded through the three previous rounds, many of the latest grantees will focus on data collection through state surveys, focus groups, and key informant interviews; this information will be gathered by grant staff, consultant vendors, or state university research centers. The grant teams will use the information they gather to inform their discussion of viable policy options. In addition, several states have formed steering committees, often appointed by the governor, that are comprised of relevant stakeholders to provide input into the process of developing options.

Some Round IV states will participate in a multistate database that integrates state and federal coverage data. The Integrated Database project[3] was developed by a team from Arkansas, a Round I SPG grantee, and is currently overseen by Joe Thompson of the ACHI. The District of Columbia, Florida, Mississippi, Missouri, and Virginia will use portions of their funds so that their state data can be included in the database, bringing the total number of participating states to 24.

The states have targeted their grant activities to their particular uninsured populations. For example, Virginia, one of the states with the highest rates of employer-sponsored insurance (ESI), will try to fold service-sector employees into its robust ESI base. Other states, such as Mississippi and Nebraska, will interview legislators as "key informants" to gauge the political prospects of a variety of coverage proposals. Although the grantees are aware that partisan viewpoints could stifle certain options, they are nevertheless determined to build the political will they need to address the uninsured in their states.

Endnotes

1 The Compacts of Freely Associated States are international treaties that give foreign citizens certain rights, such as unrestricted entry to the U.S., as well as access to residence, education, health care and employment in the U.S. The Compact of Free Association was established in 1986 and includes residents of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Because of its close proximity, many Pacific Islanders come to Hawaii to receive health care services.

2 The Prepaid Health Care Act mandates that employers provide health insurance to their employees. Employers must cover a portion of the employee's individual premium such that the employee's share is no more than 1.5 percent of his/her annual wages. Under this law, employees who regularly work 19.5 hours or more per week are covered. State and federal employees, sole proprietors, and seasonal workers are excluded from the provision. Hawaii is the only state in the nation with such a law.

3 This database integrates federal and state-level coverage data that was obtained and distilled from the Behavioral Risk Factor Surveillance System, Current Population Survey, and County Business patterns. The database is accessible via an Internet site that is password protected for security. For more information, contact Shirley Tyson, program manager at the Arkansas Center for Health Improvement, at 501.660.7563 or tysonshirley@uams.edu.

New from SCI in 2003

HIFA at Age Two: Opportunities and Limitations for States
November 2003
by Theresa Sachs
www.statecoverage.net/pdf/issuebrief1103hifa.pdf

This brief examines the evolution of the Health Insurance Flexibility and Accountability (HIFA) initiative since its inception more than two years ago. Theresa Sachs of EP&P Consulting explores how states have used HIFA, the limits that have been placed on the initiative by federal policy decisions, and the issues that remain unresolved. Finally, the brief discusses factors that may influence HIFA in the future.

Utah's Primary Care Network
November 2003
prepared by Isabel Friedenzohn and Rod Betit
www.statecoverage.net/utahprofile.htm

The State Coverage Initiatives (SCI) program released the first in a new series of Web-only publications called "Profiles in Coverage" in 2003. These products, which are in a Q & A format, will examine state coverage programs from the perspective of the state officials responsible for their design and implementation.

In the first Profile in Coverage, Rod Betit, former executive director of the Utah Department of Health, answers questions about the inception of Utah's Primary Care Network (PCN), its successes and challenges, as well as the lessons he learned through the process of designing and implementing the program. Utah was awarded a first-of-its-kind Medicaid 1115 waiver in March 2002 to implement the PCN, which provides primary care and preventive services to low-income adults who would otherwise lack health insurance.

Evaluating ROI in Disease Management Programs
November 2003
by Thomas W. Wilson
www.statecoverage.net/pdf/issuebrief1103.pdf

Tom Wilson examines the methodological issues involved in determining whether disease management (DM) programs save money and improve health outcomes. Key issues include selecting a reference population that is equivalent to the group receiving DM services and ensuring the comparability of metrics used to assess outcomes.

Stateside
October 2003
www.statecoverage.net/pdf/scinews1003.pdf

This newsletter examines the recent focus on dual eligibles in the health care debate. It also outlines SCI's work to assist states in designing and implementing premium assistance programs. Finally, it includes an interview with Paul Wallace-Brodeur, a former Vermont Medicaid director with more than 40 years of experience in public service.

Mapping State Health Insurance Markets, 2001: Structure and Change
September 2003
by Deborah Chollet, Fabrice Smieliauskas, and Madeleine Konig
www.statecoverage.net/pdf/mapping2001.pdf

This monograph synthesizes information drawn from the Health Insurer Database of the 50 states and the District of Columbia, updating 1997 data to 2001. The database was created by The Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program and Mathematica Policy Research to give state policymakers an opportunity to make comparative

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state analyses and assess national trends. It contains information about every U.S. health insurance company that writes at least $500,000 of major medical coverage in the group or individual market. It also explores the effect that fewer, larger insurers have had on state markets and the implications of this trend for the future.

Stateside
April 2003
www.statecoverage.net/publications.htm

SCI's spring 2003 newsletter highlights how states are looking to ensure disease management savings. It also includes testimonials by senior state health policy officials on how they are creatively approaching coverage issues in their states and an interview with outgoing Arkansas Medicaid Director Ray Hanley.

State Experience with Benefit Design
April 2003
by Isabel Friedenzohn
www.statecoverage.net/pdf/issuebrief403benefits.pdf

This brief highlights the experiences of Oregon, Utah, and Washington—each of which have embarked on the process of modifying their Medicaid benefits. It also draws on other relevant examples of states that have developed new benefit strategies in the past two years.

Group Purchasing Arrangements: Issues for States
April 2003
by Mila Kofman
www.statecoverage.net/pdf/issuebrief403.pdf

In this brief, Mila Kofman examines the many issues that state policymakers will have to consider as they establish and promote Group Purchasing Arrangements. She also looks at the federal laws that affect states' authority to regulate GPAs.

In Focus-The Trade Act of 2002: Coverage Options for States
March 2003
by Stan Dorn
www.statecoverage.net/pdf/issuebrief303trade.pdf

This brief answers some of the common questions that state officials may have about the Trade Act of 2002 and how it applies to health insurance tax credits, the expanded National Emergency Grant program for health coverage, and federal grants for state high-risk pools.

Leveraging Local Dollars to Expand Coverage in Lean Times
February 2003
by Caton Fenz
www.statecoverage.net/pdf/issuebrief203.pdf

In light of increases in spending and decreases in state revenues, many states are examining alternative methods of financing coverage. In this issue brief, Caton Fenz examines how states can access local dollars and use them to draw additional funding from the federal government.

LOOKING AHEAD

As states enter 2004, Medicaid spending continues to outpace revenue growth, and state budget situations remain precarious. However, for the first time in three years, state officials are cautiously optimistic that their fiscal pictures have begun to brighten. According to a report published by the National Conference of State Legislatures in December, fewer states are reporting budget gaps at the beginning of fiscal year (FY) 2004 compared to the early months of FY 2003.

Yet such improvement appears to be uneven among the states, with many still entrenched in dire economic situations. Moreover, some state fiscal officers anticipate that states will revert to crisis mode in FY 2005—after the one-time federal financial assistance has been depleted. For the foreseeable future, states will likely continue their strategy of preserving coverage incrementally and partnering with the federal government and private sector to make existing dollars stretch farther.

Medicare reform was the big health reform news of 2003, and it will undoubtedly take time before states, the private sector, or the public fully understand the implications of the new legislation. Meanwhile, the federal government will be engrossed in implementing the program and preparing for the prescription drug benefit to take effect in 2006.

Initial responses from states indicate that they are overwhelmed by the new legislation and uncertain of its impact on them. They are particularly concerned with the "clawback" provision included in the massive legislation, which requires states to return a large portion of their savings to the federal government when the program is implemented in 2006. In the nearer term, states are waiting to gauge the effects of the federal law's subsidy plan for low-income seniors—which, beginning in 2004, will provide individuals up to $600 per year through a drug rebate card. It's not yet clear how the subsidy will influence existing state-run drug programs for older adults.

In 2004, insurance companies will begin marketing a component of the new Medicare bill—health savings accounts (HSAs). These accounts pair a high-deductible insurance policy with a tax-free savings account. They are similar to Medical Savings Accounts, which were introduced in 1996 but never became popular among insurers due to restrictions on who could own them and the number of policies that could be sold. HSAs appear to have fewer limitations and several attractive features, such as lower deductibles and tax-favored rollovers, which have captured the attention of purchasers and plans. The impact they will have on state individual and small group markets remains to be seen.

Immediately following President Bush's signing of the Medicare legislation, Senate Majority Leader Bill Frist (R-Tenn.) pledged to turn his attention to the issue of the uninsured. As Bush heads into an election year, he will likely endorse approaches that include tax credits to help pay for coverage, expanded eligibility for current programs, and association health plans for small businesses.

The Democratic presidential candidates have also made health care coverage a prominent issue in their campaigns. They have put forth bold plans, some of which seek to achieve universal coverage. After a decade during which incrementalism reigned, it will be interesting to see how the Democratic candidates square off against Bush, who will undoubtedly adopt a more conservative approach than many of them.

Medicaid reform may resurface in 2004 as well. In 2003, the House Energy and Commerce Committee formed a task force on Medicaid. It has conducted five reform hearings so far, and more are expected in 2004. The task force is currently discussing a plan that would provide more funding to states from 2004 through 2006. However, states would have to restrict growth of their programs after the plan was implemented.

Several states, including California and Maine, have embarked on innovative expansions in 2003 that will inform others about how they can continue to make inroads, even during trying times. As the fourth group of states funded through the Health Resources and Services Administration's State Planning Grant program develop their coverage plans, their experiences will be similarly informative to other states and the federal government.

Despite the bleak circumstances they faced, the states have succeeded in cultivating hope this year. If states remain as committed to their uninsured moving forward as they have been for the past several years, those efforts should continue to bloom.

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